

JAMES HAAVEN 10/17/2014

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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MINNESOTA

KEVIN SCOTT KARSJENS,
DAVID LEROY GAMBLE JR.,
et al.,

Plaintiffs,

v.

No. 11-3659 (DWF/JJK)

LUCINDA JESSON, DENNIS
BENSON, et al.,

Defendants.

VIDEO DEPOSITION OF JAMES HAAVEN
Taken in behalf of Plaintiffs
Friday, October 17, 2014

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1 BE IT REMEMBERED THAT, pursuant to the Federal
2 Rules of Civil Procedure, the deposition of JAMES
3 HAAVEN was taken before Marilynn T. Hoover, a
4 Certified Shorthand Reporter in Oregon; on Friday,
5 October 17, 2014, commencing at the hour of 9:17
6 a.m.; at BEOVICH WALTER & FRIEND, 1001 S.W. Fifth
7 Avenue, Suite 1200, in Portland, Oregon.

8
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24
25 ALSO PRESENT: Mr. Mick Irwin, videographer

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23 JAMES HAAVEN,
24 called as a witness, being duly sworn on oath, was
25 examined and did testify as follows:

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6 Would you please state your name for the
7 record.

8 A. Yes. James Lee Haaven.

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14 Q. And so in what years did you perform
15 annual evaluations for MSOP?

16 A. Again, I don't -- I believe the first one
17 was either -- it was 2006, I believe; and then we
18 did a review every year except 2008, I believe, is
19 the one year that we didn't.

20 Q. And do you know why there was no review
21 that year?

22 A. That year was because there was a major
23 change, a shift organizationally, as to under what
24 governmental body that MSOP would fall, as well as a
25 pretty significant change of internal leadership.

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1 So it was more a logistical issue, just trying to
2 organize such a thing and...

3 Q. And -- Well, okay. First I'd like to
4 cover some of your background.

5 Can you give me a -- Describe your
6 educational background for me.

7 A. My educational -- Well, let's see. I
8 graduated with a bachelor's of science degree in
9 civil engineering in 1966 and then attended a
10 community college for 15 credits but did not finish
11 a degree in psychology. I then completed a degree,
12 a bachelor of arts degree, in sociology in 1973. In
13 1975, I completed a master's of arts degree in
14 behavioral science from Pacific Lutheran University
15 in Tacoma, Washington.

16 Q. And outside of those degrees, do you have
17 any sort of professional certificates or licenses?

18 A. I was certified -- a certified clinician
19 here in the state of Oregon, but I don't believe I'm
20 certified at the moment. I was just checking my --
21 whether I had paid my dues for this year yet, so I'm
22 not sure. Since I don't do any work in this area, I
23 don't pay any particular attention; but I was
24 certified as a certified clinician. Those are the
25 only certifications that I have.

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1 Q. And have you had any sort of training on
2 sex offender treatment specifically?

3 A. Yes. Extensively through conferences, and
4 I've been actively engaged with the Association for
5 Treatment of Sexual Abusers since its founding; and
6 so I'm actively engaged in all of the training
7 processes through that, as well as many other
8 conferences I've attended through the years.

9 Q. So outside of ATSA, are you a member of
10 other professional organizations related to
11 treatment?

12 A. Well, National Association of Persons with
13 Developmental Disabilities is the only other
14 organization that I'm a member of.

15 Q. And have you ever published any papers on
16 the -- in the area of sex offender treatment or...

17 A. Yes.

18 Q. And what were the -- How many of the
19 papers?

20 A. You know, I don't know for sure, but I'm
21 going to guess it's at about eight or nine. One --
22 Almost all of those were -- One -- About ten: One
23 informational packet, the rest were articles, and
24 one was a book.

25 Q. And what was the book on?

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1 A. The book was just -- I think it was called
2 Model Residential Program. It was written in 1990,
3 Residential -- Model Residential Program for Persons
4 with Intellectual Disabilities, with sexual
5 offending issues.

6 Q. And since 1990, has -- have you updated
7 that book?

8 A. Not that book, no.

9 Q. And what are the -- You said you'd
10 published other --

11 A. Yes. I've published other chapters in
12 books, regarding treatment issues, assessment
13 issues. I'm also one of the co-authors and primary
14 authors of the development of a new risk assessment
15 tool called Armadillo S.

16 Q. Armadillo S?

17 A. The Armadillo S.

18 Q. And what does that measure?

19 A. Again, it's a risk management tool for
20 persons with intellectual disabilities, with sexual
21 offending issues.

22 Q. Is that test still in the developmental
23 stage or is that used anywhere?

24 A. It is now used here in the United States
25 as well as other countries. The Web site for it is

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1 Armadillo.net.

2 Q. And how is that different than other -- Is
3 this an actuarial test?

4 A. No, it isn't, actually. It was -- Again,
5 it was designed as a management guideline assessment
6 process to assist people in how to develop treatment
7 strategies and support systems for persons with
8 these particular types of problems. In the process,
9 of course, some of the authors of the tool, as well
10 as other persons around the country, have now used
11 that tool in trying to see if it's also predictive
12 -- has predictive validity. There's only been three
13 studies done in that regards -- somewhat, again,
14 small studies; so at this point we could not say
15 that it's a predictive instrument yet.

16 Q. And who are the co-authors of that, the
17 Armadillo S?

18 A. Doug Bower, and William Lindsay, and
19 Joseph Skadalin, S-K-A-D-A-L-I-N, and Freese, Mike
20 Freese, and Frank Limbrick. They're all from other
21 countries; so I say by name, yet I've never met --
22 I've only met two others, two of them.

23 Q. And so what -- Why did you -- What

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11 Q. And do you know how many programs use the
12 Armadillo?

13 A. I don't. They use it in a broad range of
14 different ways. I do know that it's -- there's
15 certainly a number of states that use this. I do
16 consulting up in New York, Pennsylvania, certainly
17 all throughout New Mexico. It's used up in Canada
18 in various areas. In fact, I'm doing trainings in
19 that regard next week in Toronto. It's used rather
20 extensively in Australia and New Zealand. It's also
21 been introduced to Scandinavian countries. It's
22 used in the United Kingdom, where I've done
23 training.

24 So, again, I really don't know, but it's
25 -- it's one of the few tools available for this type

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1 of issue in this area, so it's...

2 Q. Okay. Do you know if the Minnesota Sex
3 Offender Program uses the Armadillo S?

4 A. They don't. They're familiar with it, but
5 the reason that it's not as applicable in this
6 regard is it's primarily used as a risk management
7 tool for persons that are moving to community
8 settings; so that's when it becomes much more
9 applicable. Within institutional settings, it
10 really doesn't give significant useful information,
11 so that's why it's not used there.

12 Q. Okay. And so, now, as I understand it,
13 you have a private practice?

14 A. I do consulting as my private practice,
15 yes --

16 Q. And what --

17 A. -- and training.

18 Q. And consulting on what specifically?

19 A. Almost all of my consulting now is pretty
20 much exclusive to special needs populations, persons
21 with -- especially with intellectual disabilities
22 and persons with mental health issues and other
23 types of psychiatric disorders.

24 Q. And is your consulting on those
25 populations generally or populations who are in

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1 prisons or some sort of confinement?

2 A. All settings. All variety of settings.

3 Q. And prior to your current consulting
4 practice, did you work in this field?

5 A. Yes.

6 Q. In what?

7 A. I worked about -- I was about eight years
8 at the -- at Western State Hospital, where I was
9 clinician and then also became program director of
10 outpatient services. And, again, that's where I
11 initially started specific work, working with issues
12 around sexual offending issues.

13 And then I was the unit director for two
14 programs in the state of Oregon, at Oregon State
15 Hospital: One program for 24 years; and the other
16 program, that I think I just previously told you
17 about, due to the class action suit, I inherited and
18 I had that for about 18 years in parallel with the
19 other program. Both of those programs are focusing
20 primarily on persons with intellectual disabilities;
21 and most of those folks, the focus was sexual
22 offending issues.

23 Q. So for -- So for the Western State
24 Hospital, that -- those were special needs people
25 with --

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1 A. They were special needs.

2 Q. And also some with sex offender issues?

3 A. Yes.

4 Q. And the same for the Oregon State
5 Hospital?

6 A. Yes.

7 Q. And when -- You were eight years at
8 Western States Hospital. Do you -- When did you
9 start there?

10 A. Must have been around 1972, I think, is
11 when I started. Between '72 and 1980 is when I was
12 there.

13 Q. And Oregon State Hospital was after that?

14 A. Was after that, until 19 -- until 2004.

15 Q. And so how -- how did you come to be an
16 evaluator for the MSOP program?

17 A. Since I had been involved with the -- with
18 the class action suit in Washington that was
19 initiated in 1994, was my initial experience with
20 civil commitment programming. After that, I became
21 more involved with doing some consulting training in
22 other civil commitment programs. It was just sort
23 of a collection of civil commitment programs -- I'm
24 trying to think now.

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1 Ridge program wanted to have an advisory team; and
2 so, in looking at who might present the expertise
3 needed, that they were looking for, they identified
4 three of us. And primarily my focus was in the area
5 around special needs programming, thing of that
6 sort. And so we just sort of came together as such
7 and were invited to be part of that; and since then,
8 we have done some other evaluations as a team.

9 Q. So is it the same group of people you work
10 with who evaluate the Wisconsin program and the
11 Minnesota program?

12 A. Yes. We don't evaluate the Wisconsin
13 program now. We did, I believe, for either five or
14 six years; I'm not sure. I think their last
15 evaluation there was four years ago, I believe.

16 Q. And do you know why -- Let me step back.
17 Do you know if that program is still
18 receiving annual evaluations?

19 A. I don't believe so. I believe ours was
20 the last -- who knows? I don't know all the
21 reasoning why; funding issues and the like.

22 But I might add, also, that the last year
23 we did an evaluation, they also expanded the
24 advisory group to two other additional people, a
25 psychiatrist and another psychologist.

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1 Q. And who -- So who were the people on the
2 original Wisconsin --

3 A. It would be Robert McGrath and William
4 Murphy who were the other two evaluators of MSOP.

5 Q. And do you know who the additional two
6 people were that were added?

7 A. It was a Dr. Stephen Hucker, and Robert
8 Hare was the psychologist -- the other psychologist.

9 Q. And is that H-A-R-E?

10 A. H-A-R-E.

11 Q. And so is that from the Hare
12 psychiatric --

13 A. Yes. PCL-R.

14 Q. PCL-R. So for the Minnesota program, do
15 you recall, was it something that MSOP contacted you
16 or...

17 A. I was -- I was asked to come to do
18 training at MSOP for the special needs program on
19 the St. Peter side in 2005, I believe. Plus, I had
20 been involved with MSOP -- in fact, I did initial
21 training for special needs population when it was
22 first developed back in 1995, I think, something of
23 that nature. I can't remember the first year. So I
24 was sort of known in that area.

25 So I was brought in in 2005 for the S -- I

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1 think they called it the special needs services
2 program of the MSOP at the time; and, in doing so,
3 they also asked me some specific questions to
4 respond to. When I did, I then shared with them
5 what we do in some of the other civil commitment
6 programs: That, by having a team look at this, you
7 get a broader perspective. And it was from those
8 discussions that they then asked -- invited us as a
9 team to return from then on. So I think -- I think
10 it was 2005 I came in; and 2006, I think, was our
11 first time as a team together.

12 Q. And do you remember specific --

25 Q. BY MR. GOODWIN: And so what other

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1 programs do you evaluate, outside of MS -- Go ahead.

2 A. MSOP is the only site that we're doing
3 right now, routinely, yearly; but we have done --
4 and, again, we haven't -- The ones that we've done
5 together, we've did approximately six years in a
6 row, six to seven years at Wisconsin. We did one
7 yearly evaluation for New York. We did a yearly
8 evaluation for Kansas. I did evaluations for the
9 special needs part of the Washington program.

10 And, again, they -- they can speak to --
11 because they have -- Bob and Bill have also done
12 some yearly reviews; and, again, I -- they would
13 have to respond to that -- for several years in
14 Florida. I did training and consultation in Florida
15 but was not part of a yearly, annual evaluation.

16 Now, I've done trainings in other civil
17 commitment programs and consultation; but, as far as
18 an actual evaluation report, that is -- I've only
19 been involved with the states I mentioned, which was
20 New York, Kansas, Minnesota, Wisconsin, and
21 Washington.

22 Q. And so what other states have you
23 consulted with, related to sex offender --

24 A. Yeah. Where I didn't do program reports,
25 like I said, one was Florida; Arizona; Texas, which

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1 is an outpatient program; and Virginia. And let me
2 think. I think I believe that's what I -- I don't
3 recall.

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24 Q. So for the Minnesota program specifically,
25 was it something that the program initiated, it

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1 sounds like, and came to you and said, "We'd like an
2 evaluation"? Or is there some sort of statutory
3 requirement that you're aware of that they -- the
4 basis for --

5 MR. IKEDA: Objection. Foundation.

6 THE WITNESS: I'm not familiar with if
7 there was any.

8 Q. BY MR. GOODWIN: Okay. So how about --
9 Can you walk me through the process of what you do
10 as part of the evaluation, how that works.

11 A. Well --

12 Q. Excuse me. As it relates to MSOP
13 specifically.

14 A. Yes. And the way in which we do this is
15 we, each year -- again, we're told we're invited, if
16 we're going to be returning to the process. If so,
17 then a meeting is set up, usually with the --
18 initially with the clinical executive director. And
19 then to decide as to, again, what is going to be the
20 structure of that, the days are going to be the same
21 days, same types of site visits, where the site
22 visits will be at, also what we feel is the areas
23 that we want to explore. And, for the most part, we
24 -- we dictate, you know, as to where the focus of
25 the attention is going to be. There might be -- The

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1 clinical director may ask -- there's some particular
2 areas of concern that they have that they'd like us
3 to look at, so they would ask us if we could
4 accommodate that in the process.

5 So that's kind of how it's initially set
6 up. And then, from there, they then set up whatever
7 logistics we ask for as to where we want to visit,
8 where we want to go, time periods, things of that
9 nature.

10 Q. And are you currently planning on
11 performing an evaluation for MSOP for this -- this
12 year?

13 A. Yes, in December.

14 Q. And, as part of that evaluation, have you
15 started the process of contacting the clinical
16 executive director yet?

17 A. Not as to the actual content of where
18 we're going to put our focus, no. Only the days
19 that we're going to be in and how many days at each
20 site.

21 Q. So for this year, are there any specific
22 areas that you've been asked to look at?

23 A. No.

24 Q. And for -- Do you recall other specific
25 areas you've been asked to look at regarding MSOP?

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1 A. Yeah. For the most part, the requests
2 from MSOP to us of specific things to look at or
3 things to respond to are actually very -- usually
4 very limited. And so I'm sort of going from memory
5 here: It seems like -- like once there was a
6 question, could we look at -- Do we think that MSOP
7 should do psychosexuals on -- with individuals who
8 -- psychosexual evaluations with persons who have
9 not been committed to the civil commitment program?
10 There was questions like, Should we integrate
11 persons that have behavioral problems into one area
12 or mix them within units? So it's questions like
13 that, but I would say it's no more than maybe four
14 or five requests over the six, seven years, that I
15 can remember specific to that. It's usually left up
16 to us: Where do we want to explore the coming year?

17 Now, we do that by looking at our reports,
18 the areas that we think need to be followed up on.
19 If there's areas that we thought that there might
20 have been some areas of concern, we want to see if
21 changes have taken place. So we pretty much set the
22 agenda. In fact, we totally set the agenda.

23 Q. Okay. And so, outside of meeting with the
24 executive clinical director, do you meet with other
25 staff?

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1 A. Not necessarily. We might coordinate some
2 logistical things, like through the clinical
3 director at St. Peter's -- Haley Fox, possibly, or
4 Tom Lundquist, in Moose Lake. But, for the most
5 part, the organizing of the evaluation process is
6 through the clinical executive director, who of
7 course is working through the executive director,
8 Nancy Johnston; but, almost exclusively, our
9 discussion is with the clinical director.

10 Q. But once you're actually into the
11 evaluation process, as part of that evaluation, do
12 you have formal meetings with clinicians who -- who
13 deal with clients --

14 A. Yes.

15 Q. -- or other people?

16 A. Yes. We are given full access to any
17 information or any persons or any settings, and so
18 we meet with the a wide array of folks --
19 administrators, clinicians, as well as we meet with
20 clients.

21 Q. So, as far as on the administration side,
22 so you meet with clinicians and -- If you can recall
23 the role -- the roles of people you meet with?

24 A. We meet with folks at all levels. We want
25 to meet with manage -- super -- clinic -- clinical

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1 supervisors; we meet with the frontline clinicians;
2 we meet with security staff, residential staff. So
3 we try to touch all levels of engagement that
4 persons are going to have with the clients.

5 Q. So, for instance, the clinicians you meet
6 with, how -- who selects which clinicians you sit
7 down with?

8 A. Well, we don't select a particular person,
9 but we select groups, and we also decide how we want
10 to meet with them. So, for instance, sometimes we
11 might not want to meet with some people
12 individually. Sometimes we asked if we could meet
13 with them as groups. Sometimes we'll say we want
14 them as a group but we don't want supervisors
15 present. So we do it in a variety of ways, kind of
16 depending on how we think we're going to get the
17 best information.

18 And it's also somewhat fluid. Once we get
19 to MSOP, the schedule may be modified and changed --
20 in fact, almost always is; because, as we see
21 particular issues, concerns, or contradictory
22 information, we want to interview and review more
23 situations and individuals; and so we'll make those
24 requests, of which MSOP always responds.

25 Q. So for a situation where you would say you

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1 want to meet with a group without the supervisors
2 present, what -- what would trigger you to want to
3 meet without the supervisors there?

4 A. Because we want them to be able to feel
5 that they can share information openly and not feel
6 any sort of pressure in that regard. Even though
7 they're not necessarily stating they feel pressure,
8 we know that anytime your boss is sitting in the
9 room, you're not going to talk the same way that you
10 would otherwise; so we try to get a range of
11 different ways that we can get information.

12 Q. So do you recall, from any of those
13 meetings specifically where you have said you don't
14 want to have supervisors there, where there's been
15 any discussion about concern about those, say,
16 clinicians, that their supervisors are -- they would
17 say something that would upset their supervisors?

18 A. I really can't speak to what would be
19 upsetting to their supervisors. Certainly, in doing
20 a process like that, they're going to share some
21 information that the supervisors, I'm sure,
22 sometimes would rather not be said -- I mean, for
23 sure.

24 Q. Okay.

25 A. But it's a -- it's a quite open process.

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1 I think, over the years -- that's the other strength
2 of coming back yearly, that there's a trust in the
3 process. We do not ever share names or particular
4 information shared by an individual, As we share
5 with them openly that what we're looking for is
6 broad themes. So, for instance, if someone says
7 that there's a problem in a particular area, we
8 don't necessarily take that as fact. We then start
9 checking to see: Is this a theme of other people
10 having the similar kinds of issues? And...

11 Q. And you said you also meet with clients as
12 part --

13 A. Yes.

14 Q. -- of the evaluation? So how -- how are
15 the clients selected that you meet with?

16 A. We do it in various -- We've done it in
17 various ways. It's usually as a group, small
18 groups. I believe the last time we did it a little
19 differently. We asked to see -- There's a -- They
20 now have sort of a representative kind of government
21 process, and so we asked if we could talk with that
22 group. We felt these are folks who are rather
23 assertive and we could have opportunity again to
24 speak with them. And, again, when we do that, we do
25 that without staff presence.

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1 Q. And do you meet -- Do you make it a point
2 to specifically meet with clients in, say, the
3 alternative program or outside of the conventional
4 treatment program?

5 A. Again, we try to get -- yeah, we try to
6 get a mix. I -- My attention particularly is
7 focused on the special needs area; and so I do,
8 maybe more than in some of the other areas, sort of
9 float around the units and have more what I'd call
10 informal contact with clients and staff. I find
11 that's a better, more useful way of trying to gather
12 information, working with special needs populations.

13 Q. So, at this point, since you've been there
14 a couple of years, I assume the people recognize you
15 and approach you?

16 A. Everybody recognizes -- Oh, yes. It's,
17 "He's back."

18 Q. You're probably pretty popular while
19 you're there.

20 A. That's good and bad.

21 Q. And so -- And then, as part of the client
22 review, I know you meet with the clients, and then
23 do you review client files? Is that part of the
24 process?

25 A. Now, we do, but not as one might in, say,

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1 what you'd call a certification or accreditation
2 process. And the reason for that is that we're
3 looking more specifically at sort of the big ticket
4 items. For instance, are the plans reflective of
5 the assessments? Are the things that they're
6 working on and measuring for progress related to
7 things that have been identified within the plans?

8 So we will make some probes into some of
9 the charts on our visits in that regard, but we
10 don't really do a chart audit per se; because there
11 also is another level of a licensure or -- of where
12 there is chart auditing. And so, you know, we trust
13 that they can do that much better than we can, in a
14 very limited amount of time we're trying to do it,
15 really, three and a half days. But, for what we
16 need to do and what we think is important for what
17 we're attempting to do on the overall effectiveness
18 of the program, we do make probes and spot checks of
19 the charts.

20 Q. And you just mentioned that you're there
21 generally for three and a half days; is that --

22 A. Well, when I say three and a half -- We're
23 actually there for the whole week, but the last day
24 is a debriefing of the -- from our -- what we've
25 seen, sort of some of the broad issues that we've

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1 seen. We debrief with the clinical director and the
2 executive director individually. So it really
3 leaves four days, and part of that day is traveling
4 between St. Peter's and Moose Lake. So I'd say
5 three and a half, for sure, full days; three and a
6 half to four days, where we're on site.

7 Q. And do you feel like that's enough time to
8 give the program an --

9 A. Yes.

21 Q. Are you familiar with other sex offender
22 treatments programs that are accredited by JCAHO?

23 A. You know, I can't specifically state who
24 is at this point. I don't know. There's -- I
25 believe there is, but they are very few that

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1 actually fall under JCAHO.

2 Q. Are there any other accreditation entities
3 that would apply to a program for sex offender
4 treatment?

5 A. Well, it depends. Sometimes states --
6 states have their own internal requirements for
7 programming. I know that -- I think Minnesota has
8 some of its own licensure requirements. So every
9 state may have its own internal licensure systems.
10 We try to stay away from the things that are already
11 being done, especially if it isn't really meeting
12 the need that we need for the more broader scope
13 questions.

14 Q. And what would be the benefit of
15 accreditation of a program?

16 A. The part that is problematic is that, even
17 under Joint Commission, no one has come up with an
18 accreditation system for person -- for programs
19 specific to sex offenders, that are high intensity
20 programs of this kind. I mean, this is a rather
21 unique group, a unique mental health situation, in a
22 sense. And, quite frankly, being involved in a
23 program, even under a class action suit at the
24 Oregon State Hospital, that was under the Joint
25 Commission standards, they basically threw up their

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1 hands and said, "We really don't have accreditation
2 standards." So it's very limited right now.

3 So there are places that do have some
4 accreditation systems, especially Canada and the
5 U.K. So then the question is: Is that a good thing
6 or not? I guess I'm not really the best person to
7 decide that, because I haven't worked actively. My
8 other -- The other two evaluators on this team have
9 been engaged actively in those two systems in Canada
10 and the U.K. and have a better insight. I would
11 only have opinions; and, quite frankly, I don't
12 believe that it's useful to share.

13 Q. So it sounds like it doesn't come as a big
14 surprise to you that MSOP is not accredited?

15 A. Not at all, no. In fact, it would be a
16 bit of a surprise if it was, considering the
17 difficulty in how you do -- how you pull that off.

18 Q. But did you say the Washington program is
19 accredited?

20 A. The Washington program, I don't believe,
21 is at this point. And I'm not sure -- and, again,
22 the other -- one the other evaluators may -- know
23 but it seemed to me that the New York program was;
24 but, again, very few.

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4 Q. And so after having spent some time
5 evaluating the Wisconsin program and the Minnesota
6 program, what is your understanding of why Wisconsin
7 has been able to successfully treat and release
8 patients, whereas Minnesota has not?

9 A. Well, there's -- there's many, many
10 different factors. First of all, this is a
11 difficult group to place, and so you have to have
12 buy-in at all levels of government and you have to
13 have -- you also have to have a system that can
14 accommodate the movement to the community. And so
15 it, depending on those variables, can have an
16 effect.

17 Wisconsin's process is a one-tier process,
18 versus Minnesota, which has a two-tier process of
19 review, to be able to move out into the community.
20 So it, by the very nature of that, usually will lend
21 itself to a much higher threshold to which someone
22 can actually move into the community. So that's one
23 piece.

24 The other part of it of course is just the
25 politics of the problem itself: Being able to find

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1 placement in the community and get cooperation
2 within the community to which that placement can
3 take place, including other -- what I'd call
4 step-down agencies, things of that nature, that will
5 take these folks.

6 So there's a lot of different pieces that
7 go into it; so as to exactly why the -- I don't
8 know. They certainly put a lot of effort and
9 funding specifically into that, as well as statutory
10 process to assist and facilitate that happening in
11 Wisconsin. As to the actual programming, I did not
12 see necessarily a change of programming that made
13 the difference. I thought their programming was
14 pretty much the same as it was before, from when
15 they were moving very few people to where they were
16 moving more people -- not, again, a large amount,
17 but more people. The programming itself, I don't
18 think, was almost -- it was secondary, from what I
19 could -- from what I could observe.

20 Q. So you'd mentioned that politics is
21 sometimes an issue here.

22 Are you aware of how politics in Minnesota
23 -- Is there -- In your opinion, do politics override
24 the clinician -- the therapeutic decisions?

25 MR. IKEDA: Object to the form.

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1 Foundation. Speculation.

2 THE WITNESS: Yeah.

3 Q. BY MR. GOODWIN: You can answer if you
4 can.

5 A. Yeah, I have no -- I really have no guess
6 on that.

7 Q. Is there a -- As part of the annual
8 evaluation, is there a written goal or objective to
9 the evaluation you do for the MSOP?

10 A. No.

11 Q. So what do you understand the purpose of
12 the annual evaluation for MSOP to be?

13 A. MSOP is inviting us to come in and take a
14 look to see if they're operating within best
15 practice standards within our field. And if there
16 are particular things -- in other words, are there
17 particular strengths that they're demonstrating that
18 should not be eroded; and, number two, are there
19 particular barriers to providing appropriate -- best
20 practice treatment, as well as movement through the
21 programs. That's our -- our overall. So it's --
22 it's a pretty broad review, but -- in other words,
23 is this an effective process to actually accomplish
24 the goal of what the MSOP is trying to accomplish?

25 Q. And do you think that this is an effective

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1 process to achieve the goal of what MSOP is trying
2 to accomplish?

3 A. Yes, I think it is, considering there's
4 barriers -- many barriers in the way of the success
5 that everybody wants to have.

6 Q. And what are those barriers that you see?

7 A. Well, I think, again, that gets kind of
8 back to the evaluation report. We've identified
9 within MSOP what we see as some of the barriers, you
10 know, limitations, and those have been articulated
11 within those evaluations. And then of course
12 there's the external barriers, over which we have no
13 control. Like I say, the review process is a bit
14 different in Minnesota than other states.

19 Q. BY MR. GOODWIN: As far as you know, has
20 MSOP ever successfully treated and released a
21 patient from its program?

22 A. They've released -- They've released
23 someone from the program. And so when you say
24 "successfully," I think the process worked as it
25 should. That particular -- That one particular

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1 person ended up back in MSOP, but those are other
2 issues; but I think the process -- yes, I think,
3 where it -- where it happened, it worked; you know,
4 it was appropriate.

5 Q. BY MR. GOODWIN: Well, so are you familiar
6 with the -- and without getting into the whole legal
7 process of it -- but are you aware that there's the
8 full discharge and then there are provisional
9 discharge options for a patient that's in MSOP?

10 A. Um-hum.

11 Q. But, to date, MSOP has not been able to
12 fully discharge any patient. Is that a surprise to
13 you?

14 A. Not a surprise, no.

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20 Q. Are you -- Are you aware that there's a
21 female patient in the MSOP program?

22 A. Yes. Yeah.

23 Q. And are you aware that she is housed in a
24 unit with other male sex offenders?

25 A. Did not know that until I read about it in

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1 a newspaper thing, I believe. And, in fact, when I
2 got that -- In fact, I realized that when I saw --
3 went through the e-mails that I think is attached.
4 I contacted my -- my other evaluator friends and
5 said, "Have you heard about this? What about that?"
6 you know.

7 So did we know that there was a female?
8 We did, vaguely, that there was an individual. We
9 -- I, quite frankly, assumed, at the time, that that
10 was part of the St. Peter's facility of this -- the
11 hospital side, of where this person was. So, in
12 fact, in that e-mail, I believe I even asked: "I'm
13 confused. Why did we not ask where this person was
14 living? And number two, conditions?" Because it
15 stymied me as to how did this, in a sense, get past
16 us? And so that question was raised.

17 Q. And in -- And what was your conclusion?
18 How do you think that happened?

19 A. I don't know. I don't know.

20 I mean, as to why we did? Because we're
21 looking at broad issues, for starters; and so when
22 you hear "a person" in a particular -- I guess we
23 just didn't focus in on that particular client. We
24 look at sort of the broad range. In other words, if
25 they had had a program or a unit for persons, female

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1 offenders, what have you, we would have looked at
2 that more prominently. I, quite frankly, wasn't
3 even quite aware, you know, where she even was
4 housed; and I still don't know quite -- well, I
5 didn't even ask the question.

6 Q. So, as part of the evaluation, did you
7 ever -- was she ever in any of the groups that --

8 A. No.

9 Q. -- that you met with?

10 A. No.

11 Q. So have you ever met --

12 A. No.

13 Q. -- with her?

14 A. No.

15 Q. Or have you -- And in your informal time
16 on the MSOP grounds, did you ever interact with her
17 at all?

18 A. No.

19 Q. Do you --

20 A. I still don't know where she's housed, or
21 was housed.

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2 Q. And what other programs are you aware of?

3 A. Well, the one I was most familiar with was
4 Washington; and they -- that person was housed
5 initially at the women's correctional facility.

6 Q. And was that also just one individual
7 or --

8 A. One individual.

9 Q. And is that the only other program you
10 know of that?

11 A. That's the only one that I've actively
12 been involved with, yeah.

13 Q. And so it sounds like, is it fair to say
14 you were surprised to learn that this -- this
15 individual, this woman, was living among men at
16 MSOP?

17 A. Yes.

18 Q. Do you think it's best practices for a
19 women to live amongst male patients in a sex
20 offender program?

21 A. No.

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1 Q. Do you -- Do you agree with that as a
2 representation of the phase 1 of the MSOP treatment?

3 A. Right. I think, with complying with
4 facility rules, there's a therapeutic purpose in
5 that regards. In other words, do they demonstrate
6 behavioral self-management such that they can comply
7 in inappropriate ways and in various stations. So
8 that is the treatment purpose, so that they then can
9 move on to other levels and more sophisticated
10 self-regulation. But I think the facility rules
11 piece, I think, is more than just compliance per se;
12 it has a very specific treatment component to it.

13 Q. Well, maybe -- Can you expand on what the
14 treatment component is?

15 A. Well, again, it really has to do with
16 being able to show attentiveness so they can get the
17 most benefit out of the treatment experience: In
18 other words, being able to sit in a group without
19 becoming highly disruptive, things of that nature,
20 so they can get full benefit.

21 Secondly, that they can have general
22 compliance within a living environment -- so, again,
23 that all the attention and focus is not on just
24 accommodating daily frustrations; that they can move
25 on to more broader treatment type of issues.

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1 So it's really more what I'd call a
2 stabilization of the person's condition, such that
3 they can get the most benefit from going into a more
4 sex offender specific kind of focus.

5 Q. And do you think it's fair to say that
6 most people who are in the MSOP program are coming
7 from -- likely coming from prison?

8 A. Yes.

9 Q. Do you think that, if they've spent some
10 time, presumably -- if they spent time in prison,
11 that they would have gained these skills to learn
12 how to comply with a structural environment such as
13 MSOP?

14 A. To some degree. To some degree, yes -- in
15 other words, the compliance, following sort of --
16 follow the rules; but not necessarily the skill set
17 to how to manage their own sense, as far as
18 attentiveness, how to get active participation
19 within the treatment process to get the full benefit
20 from the experience. And that's what the focus,
21 then, has to be for -- in many ways, it's
22 preparation for treatment; and that you don't
23 usually receive in an institutional setting.

24 Q. And just to step back: Have you been
25 involved in any sex offender treatment programs in

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1 prison settings?

2 A. Yes.

3 Q. In which -- which -- which prisons or, I
4 should say, which states?

5 A. Well, in the state of Oregon. And I'm
6 actively engaged in all the prison systems of
7 Scotland and England. I'm engaged in -- Let me
8 think. I was involved of course with Washington in
9 their prison system, as well, before, other than
10 just their civil commitment program.

11 Those are the only that I can think of on
12 site. I mean, I've done a lot of training in
13 states, specific to institutional treatment
14 programming within the prisons; but as to actively
15 engaged, going into the prisons, looking at their
16 facilities, looking at the process, I can't think
17 beyond what I just mentioned.

18 Q. So you have not had any involvement with
19 the Minnesota --

20 A. Corrections?

21 Q. -- corrections?

22 A. Not, again, where I went -- I'm trying to
23 think. Have I ever gone on site? I've had a lot of
24 discussions with folks with their sex offender
25 program in the correctional system through the

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1 years, in providing information, curriculum, things
2 of that nature. But I'm just trying to think now,
3 have I ever been? I don't think I've actually been
4 on the site, corrections site.

5 Q. Well, how -- how is MSOP different from a
6 prison to you?

7 A. Well, of course, for starters, the intent
8 of course is versus -- is different in and it's
9 reflected in the environment. For instance, rather
10 than just containment, safe -- safety within that
11 containment, that it has a therapeutic focus; so the
12 environmental aspect of it is part of the therapy
13 process. So there's a softening -- So starting, for
14 starters, just environmentally, there's a softening
15 of the environment to make it more therapeutic.

16 Q. And how would -- How do you -- How is it
17 softened? Can you describe the softening?

18 A. In a number of different ways. And,
19 again, that's even part of our discussions in our
20 reports. But by the very furniture that one puts
21 someplace, is putting carpeting, having collection
22 areas to where people can be engaged in activity.
23 It's a -- The interaction between security staff and
24 clients is a significant difference in the two types
25 of settings, because a security staff have their

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1 primary role as security, but yet there's a
2 therapeutic component to what they're doing. And,
3 thirdly, of course is the activity itself. The
4 activities themselves are introduced to provide a
5 particular treatment outcome, where, in prison,
6 there isn't activity specific for treatment outcome.
7 There might be diversional activities to keep peace,
8 peace on the ranch, but it's a very different kind
9 of intensity of focus in that regard.

10 Q. But as far as the -- for instance, the new
11 unit that was constructed up at MSOP, is the overall
12 layout of the building with the housing units and
13 where the patients sleep, is that comparable to a
14 prison layout?

15 A. Yes. If you're talking about the new
16 complex, the 90-bed -- 96-bed units?

17 Q. Right.

18 A. Yes.

19 Q. And even the -- I believe there's
20 something like 68 unit -- 68-bed units --

21 A. Right. Pods, yeah. Yeah, I'd say that
22 structure is similar to prison settings.

23 Q. Does that -- In your opinion, does that
24 structure inhibit the therapeutic nature of --

25 A. I think, again, in our reports, we

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1 reflected our concerns, community reports, that type
2 of architectural approach and structure can be
3 limiting and can create barriers; and, therefore, we
4 suggested that this is an area that needs to have
5 attention in how to soften that issue, how to
6 address the counter-therapeutic aspect of that kind
7 of an environmental structure.

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9 Q. Okay. In the next page, if you go to page
10 57, it talks about the type of treatment at MSOP,
11 towards the bottom, I think it's the last paragraph,
12 and it talks about the type of treatment.

13 So, "the treatment at MSOP facilities
14 consists primarily of six hours of group therapy.
15 Group therapy is commonly used in sex offender
16 treatment programs. Individual therapy is provided
17 only in special circumstances at Moose Lake.
18 Individual therapy is available for clients in
19 phase 3 of the program at St. Peter."

20 And, again, this is from 2011. Do you
21 know, has that changed?

22 A. It has changed somewhat. Again, it's in
23 the report. Because each year, I believe -- this is
24 2010 -- 2011, I think that it went to something like
25 eight hours, and I think 2012 was -- or 2013 went up

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1 to nine; so there's been a gradual continued
2 increase in treatment hours.

15 Q. Do you think individual therapy would be
16 appropriate for patients in phase 1 of treatment?

17 A. I think it has limited use. It would be
18 much more of a -- it would be very focused. In
19 general, I think, considering what the focus is of
20 that phase, I think that it's -- it is less -- would
21 be less called for.

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10 Q. BY MR. GOODWIN: Well, when -- If you've
11 been evaluating the program since 2006 and there
12 have been leadership changes, when there's
13 leadership changes in the program, is there
14 generally a change to the structure of the program?

15 A. Yes.

16 Q. And do you know why that would be?

17 A. Well, there's -- there's a number of
18 reasons. You get a new set of eyes looking at the
19 issues. And, secondly, a person may come in with
20 additional kinds of expertise that they want to
21 introduce into the -- into the system. I mean, you
22 know, it's hard -- You look at these programs, in
23 particular MSOP specifically, with -- they have gone
24 through remarkable amount of change, you know, as to
25 structure leadership changes as well as then just

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1 the growth. The growth process has been very
2 significant in relation to the many programs that we
3 see. So does that cause some disruption? Yes.

4 Q. Do you think that disruption has held
5 clients back from progressing through the program?

6 A. I can't speak specifically, but I'd be
7 inclined to think that it would have some impact.

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18 Q. Okay. And if you would turn to the next
19 page, 62, it's talking about the amount of
20 treatment. And if I -- And, again we'll get to your
21 report specifically in a little bit. But if I
22 recall correctly, your evaluations have found MSOP,
23 the amount of treatment to be within the range of
24 best practices but at the lower end. Is that fair
25 to say?

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1 A. I think we made a statement, something in
2 regards to "lower end" in one of our earlier ones,
3 as that has moved up; that now the level of
4 treatment services -- or treatment dosage, as such,
5 is nine hours, I believe was the last, falls well
6 within the mean of other civil commitment programs.

7 Q. Okay. And here, if you look, there's a
8 bullet point about a third of the way down the page:
9 "The amount of treatment delivered at MSOP
10 facilities is lower than at any other adult
11 inpatient treatment program in the state."

12 And if you -- if you go down a little
13 further, it talks about how the Department of
14 Corrections has a minimum of average 12 hours per
15 week for sex offender treatment in the primary
16 phases of treatment. And further down, it talks
17 about Alpha Human Services, which is a program
18 outside of the Department of Human Services, the
19 Department of Corrections, where it provides a 20.5
20 hours of scheduled group therapy per week.

21 Does it come as a surprise to you that a
22 program that's designed specifically for inpatient
23 sex offender treatment offers less treatment than
24 these other programs?

25 A. Not necessarily -- because, again, the 12

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1 hours versus nine hours, the definition is what
2 treatment is.

3 I do know that at MSOP they are very
4 sensitive to the fact that treatment is treatment.
5 In other words, there's a number of things that can
6 be therapeutic but not necessarily would be seen as
7 treatment hours, being looked at through sort of a
8 legal microscope. And so I think they've always
9 been quite sensitive about making sure that their
10 hours meet that criteria.

11 Now, I don't know what the other programs
12 -- when they say 12 hours or 14 hours, I'm really
13 not sure. Sometimes some people look at certain
14 recreational hours that are prescriptive in some way
15 and they look at that as a therapeutic process. I
16 used to do that in the programs I was involved with
17 all the time and meet Joint Commission standards;
18 but yet at MSOP they do not do that. If they in
19 fact did that, as I had suggested early years on,
20 they more than likely would be scrutinized that
21 that's really not treatment hours; but yet it would
22 meet accreditation standards.

23 So I don't know what this sort of means.
24 All I know is that they fall well within the mean of
25 other civil commitment programs of sex offender

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¹ specific treatment.

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3 Do you think that's a valid criticism of
4 the program?

5 A. I don't think -- I don't think it really
6 states that more -- That question -- That issue is
7 much more complex than what that states. I think it
8 understates the issue. For instance, from the
9 literature, using the risk principle, the
10 risk-needs-responsivity model, that the -- that
11 higher risk should have higher level of intensity of
12 treatment. That makes sense. Then the question is:
13 How intense should it be?

14 When you take a look at what does
15 "intense" mean, and you look at, especially from the
16 literature from what -- the "what works" literature
17 that identified the whole risk principle came from,
18 the Canadian system, that nine hours a week would be
19 considered high-level intensity treatment.

20 So, with that said, then the question
21 comes back to: Yeah, but what about these other
22 programs that have more? Well, one can raise the
23 question: Maybe they're doing more treatment than
24 they need to or should. Because part of the risk
25 principle is this: That if you have lower risk and

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1 you're providing high-risk intensity, in fact it
2 could be contraindicated.

3 So one could almost make the argument that
4 it's sort of one size fits all. Now, at MSOP it is
5 sort of one size fits all, in that they've all been
6 identified as high-risk individuals. So I don't
7 think -- I think it can be very misleading, what
8 that says, from my -- from my judgment.

9 MR. GOODWIN: Okay. Do you want to take a

24 Are you -- Are you familiar with the
25 matrix?

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1 A. Yes.

2 Q. And is that -- It sounds like it's a
3 fairly common structure for this type of treatment
4 program?

5 A. Yes.

15 Q. BY MR. GOODWIN: Well, how about in 2011,
16 when this was written? Do you think, in 2011, at
17 that time, that the matrix factors were overly
18 subjective?

19 A. We addressed in a number of our
20 evaluations the need for more clarity and behavioral
21 markers in regards to the matrix process. So when
22 you say '11: '11 was better than '10, and '10 was
23 better than '09; so there's been ongoing progress in
24 that regard, but we have indicated that -- what has
25 been an ongoing issue in giving attention to the

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1 definition.

2 Q. Do you think that, or have you seen MSOP
3 establish more objective measures for these
4 matrix --

5 A. Yes.

6 Q. And what would be an example of --

7 A. Well, I can't give a specific example,
8 other than to say that they -- they created a Likert
9 scale for measurement -- and, again, when I was
10 involved with the phase progression evaluation --
11 that gave more behavioral description to all of the
12 various treatment targets, areas of the matrix
13 system. So it was significantly improved from what
14 we saw certainly back in 2009; there's been a
15 continual improvement in that regard.

16 Q. And you said a Likert scale. What is a
17 Likert scale?

18 A. A Likert scale is a one to five and what
19 does each -- if you give it a one or two, what does
20 that mean behaviorally? How would you know it's a
21 two? It isn't just -- Rather than guessing, how is
22 it actually defined in such a way that you'd know
23 how to give it an actual numerical score? And that
24 definition and behavioral clarity was significantly
25 improved over the past three years, the past three

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¹ evaluations that we looked at.

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23 Well, first of all is the PPG, or the
24 penile plethysmograph, is that a -- as far as you
25 know, a valid tool to measure sexual interest?

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1 A. It's one of the -- Yes, it's one of the
2 tools that oftentimes is used in the battery for
3 measuring deviant sexual arousal.

4 Q. Is that -- Would you characterize that as
5 a reliable measure of deviant sexual arousal?

6 A. It's -- Like most of these tools, it
7 should not be relied upon on its own; but, yeah,
8 it's a common and important assessment tool as part
9 of the battery of assessing deviant sexual arousal.

10 Q. And do you know when PPGs are administered
11 in MSOP, as far as by -- what I mean, in the
12 treatment progression of PPG?

13 A. You know, I don't know exactly, but I'm
14 assuming that this is done from a treatment
15 perspective; that once they get into phase 2, it's

22 Q. Okay. Do you know when a polygraph would
23 be administered to an individual in the MSOP
24 program?

25 A. Well, my understanding is polygraph is

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1 first initiated when they're starting to do their
2 disclosures of past history, past offenses -- which
3 is, again, usually the first part of this phase 2;
4 but, again, I can't -- I can't say specifically just
5 when it's initiated. But the -- I knew -- I know
6 more about the intent: The intent is to identify an
7 accurate sexual history.

8 Q. Okay. And the Abel Assessment of Sexual
9 Interest, the same, is that -- Well, first of all,
10 what is the Abel Assessment of Sexual Interest?

11 A. It's what we call a visual reaction time.
12 Instead of measuring penile reactive response to
13 stimuli, it's -- instead, it is a visual reaction to
14 stimuli. So as you respond to a picture, you then
15 hit a button, and so how quickly you respond to that
16 visual reaction is being measured. So it's a
17 measurement of sexual interest versus just sexual
18 arousal.

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18 Q. Okay. And then if you'd turn over to page
19 79, it addresses clients with cognitive deficits.
20 And in the section right by the alternative program,
21 on the side there, there's a point: "MSOP's lowest
22 functioning clients may not be able to complete the
23 treatment program."

24 Do you think that's an accurate statement?

25 MR. IKEDA: Objection. Vague as to time.

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1 Q. BY MR. GOODWIN: Do you think it was
2 accurate in 2011?

3 A. There may have been some -- There may have
4 been some clients that may have had difficulty with
5 the material. And I believe we shared that in one
6 of the reports -- I can't remember it was the 2011
7 report -- to make sure that, with the new curriculum
8 that they were developing, the psychoeducational
9 curriculum, that some of that needed the language.
10 And, again, the MSOP was well aware of that and, in
11 fact, were working on that. But that was one of the
12 responses we had in our evaluation, that some of the
13 material is still at a higher level than what might
14 be comprehended by some of the clients.

15 Q. And, granted, you -- I know you haven't
16 conducted your evaluation for the 2014 year yet;
17 but, as far as you know, in 2013, had MSOP addressed
18 those issues?

19 A. They had addressed most of those issues.
20 They just hadn't changed the language on all of the
21 psychoeducational modules, but -- So what that meant
22 was we went in and looked what they were actually
23 doing within the classroom itself. And, for the
24 most part, what we saw was that the facilitators
25 were adapting information. What we suggested,

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1 again, that it needs to be more manualized so
2 everybody is doing the same thing. But they were --
3 it was -- they were making reasonable accommodation,
4 from what we observed.

5 Q. And, as far as you know, have -- has the
6 treatment for people with these cognitive
7 difficulties been manualized?

8 A. It hasn't been completed, but they are in
9 the process of doing that.

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17 Q. Well, if there's roughly 700 people in the
18 MSOP program and, say, roughly a hundred people are
19 in the alternative program, does that strike you as
20 a high percentage of people with these cognitive
21 disabilities in a program like this?

22 A. No. No. We generally see that -- you're
23 talking about 10 to 15 percent, to see people fall
24 in special needs, because keeping in mind
25 alternative programs, a broad -- somewhat a broad

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1 range of folks might fall into that. And so, yeah,
2 that seems reasonable from other experience and
3 settings I've been in.

20 Q. As far as you know, has there been any
21 change to the -- to the program for alternative
22 program clients, where they have a different
23 yardstick per se to be measured by for completion of
24 the program?

25 A. They are, but I can't say specifically

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1 what that is; but, definitely, the threshold has
2 been modified. As to what degree it's been modified
3 on paper, I certainly know that when they review as
4 to -- anytime that you have a scoring of the matrix,
5 there's some subjectivity to the process. And all
6 I'm saying is that, one, there's been a significant
7 change as to the thinking about what the criteria of
8 the threshold should be; and, number two, they're
9 actively engaged in the program of actually
10 redefining what the thresholds are as well.

11 Q. And outside of the clients who are in the
12 alternative program, there's been some -- and it
13 shows up in the auditor's report, about concern
14 about clients who are not officially in the
15 alternative program but have other cognitive or
16 mental illness problems that are so significant that
17 that's interrupting their ability to get through the
18 treatment program.

19 Are you aware of any efforts to address
20 how to modify the program to fit people, say, with
21 cognitive difficulties, that don't score into the
22 alternative program officially?

23 A. I can't speak specifically to what
24 mechanisms have been implemented per se. We've had
25 a lot of discussion in this regard, in the last

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1 three years, within our reports. And part of that
2 is sort of having a process by which, if a person
3 isn't moving -- and there might be barriers to why
4 they're moving, that may be the very issues you said
5 -- there needs to be a mechanism in place that
6 alerts the system that they're not moving and there
7 are some issues that need to be addressed, and that
8 there is a response to that, in other words, a
9 written response as to why that person isn't making
10 it and what accommodation should be made, especially
11 unique to a person who's having issues with mental
12 health or mental issue -- mental illness types of
13 issues.

14 So we have talked in terms of a mechanism
15 needs to be instituted that catches these folks and
16 then creates a sense of accountability that we're
17 doing something about that. And that's been, I
18 believe, in our last two reports we've shared that,
19 as well as in the phase progression report, I think
20 that was also stated as a mechanism to be
21 instituted.

22 Q. And, as far as you know, has such a
23 mechanism been put in place in MSOP?

24 A. The last report, we did not see a formal
25 mechanism; it's been more of an informal -- in other

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1 words, a person moving within the team process
2 there's a discussion: What's holding the person up,
3 what have you. We suggested a bit more formalized
4 approach to that process, and a more documented
5 approach.

6 Q. But at this point is there any formal
7 process to catch these people?

8 A. My recollection, we did not see that in
9 the last evaluation, a formal procedural process and
10 how that happens.

20 Q. Have you had any -- Are you aware of
21 clients in the program who -- who can no longer --
22 who can learn no more from the MSOP treatment?

23 A. Again, I can't speak to specific clients;
24 I can only look at it in looking at the alternative
25 program. And we have suggested in the reports that

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1 there are clients that may likely have reached
2 maximum benefit within that experience and could
3 receive services in a different setting, and -- and,
4 again, a mechanism on how -- how that is done.

5 Certainly, MSOP, in our last meeting, a
6 lot of discussions as to attempts to do that. I
7 think, at the time, there was attempt to transfer
8 and move some folks to Cambridge; and I think there
9 was some limitations put on that, outside of the
10 MSOP process. So there's a great deal of attention
11 being given to that, and it's very likely that there
12 are some folks that are -- have received a maximum
13 benefit.

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22 Q. Well, so for -- Would you say that you see
23 MSOP as coming from a correctional perspective?
24 A. Not a correction -- It comes from a
25 treatment perspective; but what I'm saying, it's

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1 more grounded in issues of -- these folks, number
2 one, have come from a correctional setting -- versus
3 St. Peter's, those folks came from community and
4 mental health settings. So that -- I guess what I'm
5 saying is that it has a correctional influence to
6 the process by the very nature of where they came
7 from, as well as some of the security procedures
8 that have to be instituted that are going to draw
9 upon correctional experience for providing security.

10 I mean, the intent and the focus has
11 always been -- from what we have seen, was from a
12 mental health perspective; but, clearly, we're
13 dealing with clients that spend most of -- many
14 years in correctional settings.

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22 Q. BY MR. GOODWIN: Okay. Well, would you --
23 Is MSOP -- Can you maybe explain a little bit about
24 the -- there's the -- is it the cognitive based
25 approach and the skills based approach? Is that a

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1 fair --

2 A. They're not separate. It utilizes a
3 cognitive behavioral focus of treatment which gives
4 particular attention to skill building. And so
5 that's -- that is what we generally see is the
6 primary focus in treatment programs in the field,
7 and that's what we said in our reports is what the
8 MSOP has been demonstrating.

20 Q. BY MR. GOODWIN: Currently, if there's an
21 individual who lacks the cognitive ability to
22 complete the program but they're kept in this MSOP
23 facility as opposed to someplace else, is that
24 counter-productive?

25 A. I think that -- that any -- anytime that

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1 -- Boy, I got something in my throat.

2 Q. Yeah.

3 A. Anytime that a person's in a program and
4 they're not able to move through the prescribed
5 steps of how to progress through that process due to
6 -- they're incapacitated in some way, whether it has
7 to do with mental health issues or intellectual
8 deficit, that issue needs to be addressed as to what
9 is another alternative for that individual, yes.

10 Q. And, to your knowledge, has -- has MSOP
11 done that?

12 A. I can't speak to specific cases. I can
13 only specifically speak to one. What we have
14 suggested in our evaluations is that they need to
15 look at alternative options. And we've also
16 suggested that, if a person gets to that state,
17 there needs to be an evaluation specific to what are
18 the barriers; again, those barriers be addressed
19 within the setting; and, if not, what are some
20 alternatives to that; and that, in our discussions
21 with the team, that they have made specific -- given
22 specific attention and effort to that.

23 Now, as to the actual results of all of
24 that, I can't speak or give any specifics to that;
25 but that has been something that clearly has been

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1 given specific attention by MSOP and us as
2 evaluators.

3 Q. So these issues that -- These
4 recommendations, as far as you know, has MSOP
5 implemented any of these recommendations that you've
6 -- or your -- the evaluators have suggested?

7 A. They've -- Yeah, they've done a number of
8 things. Again, they've tried to find some
9 alternative placement. They have made -- tried to
10 make adjustments within the system, for instance,
11 when you said "cognitive," some of the cognitive
12 therapies, and addressing those issues in ways that
13 are appropriate for persons at this level of
14 functioning. So they have made significant change
15 of accommodation of the actual treatment materials
16 and the treatment focus, and they are looking and
17 have been looking at alternative placements.

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23 Q. Okay. Do you -- As far as you know, does
24 MSOP provide individualized treatment plans for each
25 patient in the MSOP program?

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1 A. Yes.

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1 Q. Okay. And down towards the bottom of page
2 83, there's the bullet point that says: "MSOP has
3 had difficulty identifying and meeting the needs of
4 some clients with low IQs, learning disabilities,
5 memory problems, and certain less obvious cognitive
6 problems."

7 And starting with 2011, do you think that
8 was a fair criticism in 2011?

9 A. Well, I guess, in terms of what -- you
10 know, what some clients -- There's going to be some
11 clients, because they're in the process of trying to
12 modify the cycle educational modules for these
13 individuals, as I had mentioned before, how to
14 identify thresholds to where the person might be
15 able to go to a less restrictive setting and reach
16 maximum benefit. So we look at sort of the themes
17 and the trends, and the trends were -- has been very
18 positive in the efforts in reducing barriers to that
19 happening. Is there some -- And 2011 still had some
20 difficulty meeting it? It would seem to me that
21 would be accurate.

22 Q. Is that accurate still today?

23 A. As of our last report two years ago, I
24 don't believe we make -- made a statement as
25 specific to that, other than, again, that there

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1 needs to be continued attention to make sure that
2 the readability of the material, things of that
3 nature, is a continual focus.

4 But, you know, this is not unique to
5 programs like this, in that persons with
6 intellectual disabilities, until it becomes much
7 more manualized, there's always going to be sort of
8 a clinical drift because you're dealing with folks
9 that have such a wide assortment of disorders. And
10 so it isn't like there's an easy way to do that.
11 Every program I've ever worked in, it's almost like
12 an ongoing project to make sure that you're adapting
13 the program to the unique needs of an individual who
14 might be mentally ill, intellectually deficit, a
15 brain trauma. You know, we're dealing with some 250
16 different syndromes when we talk about special needs
17 clients.

18 So it's an ongoing process. Our
19 evaluations has been that -- that we shared some of
20 the areas to give continued attention to, and that
21 there has been significant movement and progress in
22 that area.

23 Q. And if you look at the last sentence in
24 the -- on the page there: "Failing to identify and
25 meet the special needs of clients at MSOP facilities

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1 can result in a client not participating in
2 treatment," and it goes on from there.

3 But do you think -- Well, first of all, do
4 you think that's accurate, that if there's a person
5 who can't participate in treatment, that would
6 affect their motivation to continue treatment?

7 A. Yes.

8 Q. And this is an issue that's -- that's come
9 up in your reports and elsewhere, that motivation is
10 a concern at MSOP, given the fact that nobody has
11 been successfully released from the program.

12 Do you -- How is MSOP addressing those
13 issues, that you've seen?

14 A. Well, I think they've been giving it a lot
15 of particular attention, and part of it is just from
16 a therapeutic perspective. They did a great deal of
17 training in the areas of motivational interviewing
18 itself, which is a motivational process, and so they
19 -- they did a lot of training in regards to that.
20 They also, I believe, have tried to, again, create
21 more what I'd call therapeutic environments to where
22 -- which is also a motivating process, as to -- They
23 have talked in terms of -- The movement has changed.
24 There has been more movement between phases, which
25 is also motivating, and so...

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1 They also have the issue of -- They
2 created, I believe, some kind of a committee that
3 had to do with -- that clients are actively engaged
4 in and doing -- looking at environmental effects and
5 to try to make the environment a more motivational
6 experience. And so I think they're doing quite a
7 range of different things.

8 I do know that they've given really a lot
9 of attention, in relation to when I see other
10 programs, to this issue, primarily because of the
11 very problems that they're fully aware of as well,
12 is that, when you don't have movement, it has
13 damaging effects on motivation of clients.

14 Q. Okay. And the next paragraph there, it's
15 talking about the issue of motivation and it starts
16 off with: "Suspensions that clients are malingering
17 can also affect whether clients' special needs are
18 identified in a timely way. Treatment is hard for
19 many clients, and clinicians sometimes suspect that
20 a client is unwilling to put in the hard work
21 required, rather than being unable to do the work."

22 From what you've seen in the program, have
23 you seen -- do you think that's an accurate
24 statement as it was in 2011?

25 A. Well, I guess I look at the various parts

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1 of that. "Suspicion the clients are malingering can
2 also affect whether the clients' special needs are
3 identified in a timely way." That can happen, yes.

4 "Treatment is hard for many clients and
5 clinicians sometimes suspect that a client is
6 unwilling to put in the hard work." That can --
7 That happens, I'm sure; but I did not see it as a
8 trend or an overarching issue, or we would have
9 identified -- we would have stated that as such in
10 our reports. Because that's the kind of thing we
11 look for, is overarching attitudes that are getting
12 in the way of progress.

13 So are there incidents of that? I would
14 expect so. And does it seem to be a prominent
15 feature over what has happened in the program? I
16 did not see that.

17 Q. And as part of your evaluation, how would
18 -- how would you identify that? Through...

19 A. The way we try to collect information,
20 because we're looking at components of the program
21 and that sort of -- just saying: Is it happening?
22 What is the quality of it happening?

23 The other thing we want to look at is sort
24 of the attitudes and the culture. And the way in
25 which we do that is, again, to meet with a broad

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1 range of folks under different experiences, talking
2 with them in groups, then debriefing with them after
3 they've done treatment activities, to kind of get a
4 feel as to how they think about their work, how they
5 think about the clients that they're working with.

6 And so we're very engaged in trying to
7 look at sort of trends that could be getting in the
8 way of creating a culture that is nonmotivating.

9 Q. Okay. And the second to last paragraph,
10 about halfway through, starts with, on the right
11 side of the paragraph: "Failure to address learning
12 disabilities or academic deficits can hold clients
13 back."

14 Do you think that's an accurate statement?

15 A. Yes. Failure to address can hold a client
16 back, yes.

17 Q. And have you seen -- How has MSOP
18 addressed that issue?

19 A. Well, obviously, initial testing, for
20 starters, as to what is the intellectual
21 functioning. Also, to a large degree, MSOP has
22 somewhat had the benefit, since they started with
23 sort of the SNS program, a lot of folks with
24 experience and working with persons with
25 intellectual disabilities. That sort of expertise

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1 has then sort of been brought to bear within the
2 MSOP program.

3 So I would suggest that more staff --
4 Likely what we saw is a lot -- staff seemed to have
5 a sensitivity to this issue and to identify when
6 people are running into intellectual deficit blocks.
7 So, to a large degree, the program has quite a bit
8 of sophistication in this regard. And how that has
9 happened? Well, part of it is training, I suppose;
10 but they also have a very engaged alternative
11 program, that's directed there by Haley Fox, who is
12 trained in this area, specifically, working with
13 these kinds of issues. So I think that has really
14 impacted the entire system. There's definitely a
15 sensitivity to these types of barriers when they're
16 being presented.

17 Q. And are you aware of -- Maybe on the
18 sensitivity to these issues, are you aware of
19 actions MSOP has taken to address them specifically?

20 A. Again, I don't -- can't -- I don't have
21 examples of particular cases. I just know that --
22 that what we observed was where they would make
23 specific adaptations to various approaches, to
24 various material that was provided to the clients.
25 So, in that sense, clearly, someone was making

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1 decisions that modifications needed to be made and
2 were being made; so I saw -- clearly saw examples of
3 that happening.

4 Q. And assuming there's been movement within
5 the program, though, to your understanding, none of
6 these people have been able to actually exit the
7 program; is that accurate?

8 A. No one has left the program, no.

22 Q. BY MR. GOODWIN: Well, do you know how
23 someone ends up in the alternative program or not?

24 A. I know one -- one route that a person --
25 If a person is having difficulties with material,

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1 and it could be because of intellectual deficit,
2 things of that nature, that are getting in the way,
3 there's team meetings of which the team then will
4 raise it to another level of review and then they
5 assess the situation at the time.

6 So there are a lot of systems in terms of
7 the treatment review and ways in which that can be
8 introduced for discussion as to whether the person
9 should be transferred, as to what the actual
10 criteria, the decision is. In many cases like this,
11 it requires more sophistication of a process than it
12 does a strict criteria, because a strict criteria
13 could miss out on -- again, there's so many nuances
14 to this kind of problem area, that you have to have
15 a good system versus specific criteria.

16 Q. BY MR. GOODWIN: But as far as you've
17 seen, does MSOP have an adequate system to --

18 A. I did not see anything that raised alarms
19 as to deficiency. There was a system in place; it
20 seemed to be working.

21 Now, we have not, obviously, gone in to
22 take a look at all cases as to whether certain
23 people have been denied or if there's persons being
24 missed. That would take a much more intense review.

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22 Q. Is other programs you look at, is that
23 standard to wait until later phases to begin
24 reintegration, or is there more of a range on them?
25 A. No. It's usually at some phase towards

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1 the end of treatment.

2 (Exhibit 3 marked.)

3 Q. BY MR. GOODWIN: Okay. I'd like to go to
4 this, I believe it's Exhibit 3, the 2011 annual
5 performance report.

6 Do you recognize this document?

7 A. No.

8 Q. Okay. Well, if you'd turn to page 35, at
9 the heading it's appendix 1.

10 A. Okay.

11 Q. And do you recognize this portion of the
12 document that I --

13 A. Yes. Yes.

14 Q. And so it lists you, Robert McGrath, and
15 William Murphy as the site visitors for the report;
16 is that correct?

17 A. Yes.

18 Q. And so you -- It also lists the date of
19 the visits as December 12th to 16th, 2011. Is
20 that --

21 A. Yes.

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19 Q. And as far as process groups, is there --
20 is it preferable to have process groups versus
21 individual therapy? Or do you know why -- I mean,
22 I'll just leave it at that.

23 Why does MSOP, as you understand it, use
24 group therapy as opposed to individual therapy?

25 A. Well, there's -- again, there's a number

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1 of reasons. What we see generally in the field is
2 that we're going to see group process used, and
3 that, by having a group dynamic, that people can
4 also learn from each other in that process, as well
5 as it increases accountability in the process
6 because there's other people that give feedback,
7 people that are also going through sort of that same
8 treatment change process.

9 So group therapy, in and of itself, can be
10 a very powerful tool in the change process. So
11 you're generally going to see -- You're always going
12 to see group process, or group therapy, as part of
13 the delivery system, working with sexual offenders.

14 Q. And is -- In the programs, other the
15 programs you look at, is individual therapy
16 typically a part of that?

17 A. Sometimes, but not always. It varies. It
18 also varies with individuals. For instance, you
19 oftentimes might see more individual therapy
20 provided for persons who have special needs issues.
21 You'll see sometimes more individual work done with
22 folks that are in alternative special needs
23 programs.

24 Q. And, currently, does -- as far as you
25 know, does MSOP offer that type of individual

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1 therapy for people in the alternative program?

2 A. Yes.

3 Q. And does it generally offer that type of
4 therapy to people in the conventional program as
5 well?

6 A. Well, it somewhat, again, varies. In the
7 conventional program phase 3, it does; and in
8 phase 2 at St. Peter's, it does. It generally does
9 not in phase 2 in Moose Lake. It doesn't mean that
10 there aren't some options or opportunity for that;
11 but, generally speaking, individual therapy is not
12 utilized in phase 2, Moose Lake.

13 Q. Now, I know there's some -- My
14 understanding is there's some patients who are in
15 phase 2 at Moose Lake and some people who are in
16 phase 2 at St. Peter.

17 A. Yes.

18 Q. Is that your understanding as well?

19 A. Yes.

20 Q. Is it different? Is the treatment
21 different if you're in the phase 2 if you're at
22 Moose Lake versus St. Peter?

23 A. I can only speak, again, sort of to our
24 comments, is that there is some difference in
25 programming between the two; and that was one of the

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1 issues we raised, that there needs to be more of
2 consolidation of consistency in that regard. And
3 one of those inconsistencies was phase 2 at Moose
4 Lake had -- did not have individual counseling, and
5 St. Peter's did.

6 Q. And do you know if that issue's been
7 resolved? Is there individual counseling available
8 at both facilities now?

9 A. I don't -- It wasn't as of the last
10 report, which would have been December 2013.

that new
21 program materials developed are appropriate for
22 clients with special needs, or develop parallel
23 materials."

24 A. Yes.

25 Q. And at the time you wrote this, since

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1 then, has that happened?

2 A. There's been progress made, but it still
3 has not been completed, especially with the change
4 of all of the manualizing of all the
5 psychoeducational modules hadn't been completed yet.

6 Q. So then, as this process is occurring, is
7 it -- is it possible that there are people who are
8 not getting treatment that they can comprehend?

9 A. No, I can't say that; because, as I said
10 before, even though it's maybe not manualized, it is
11 -- it's not -- we questioned what the consistency
12 might be, since they are adapting those issues as
13 they go on. So the facilitators will adapt to
14 particular needs of the client at the time.

15 So we did see they're adapting. Now, the
16 question is: Is it consistent across the board for
17 all folks, since we don't have a manualized system
18 to look at? So it raised a question, but we -- I
19 can't answer the question as to whether there were
20 no adaptations made.

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5 Q. And if you'd skip down under the heading
6 5, "program sequence," the last full paragraph
7 there. Again, this issue of: "We are concerned
8 about the high number of clients in phase 1 of the
9 program and small number of clients in phase 3 of
10 the program."

11 Is -- In 2013, is that still a valid
12 concern?

13 A. Yes. We've presented it as a valid
14 concern, I believe, in all of our reports since
15 2006.

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17 So taking that first part about having the
18 program ensure that about 80 percent of the focus of
19 the treatment manual is on dynamic risk factors: Do
20 you know if that is the case in the current program
21 manual?

22 A. I don't think we spoke specifically to
23 that; because, at this point in time, again, in
24 2011, it was still draft form. And that -- The
25 reason I believe we did not address that is that we

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1 felt that it was addressing the focus for being
2 empirically supported dynamic risk factors, that
3 piece of it.

4 That's the part of that sentence you're
5 talking about; right?

6 Q. Right, that first part.

7 A. All right.

8 Q. And so if 80 percent of the manual is
9 focused on those dynamic risk factors, then what
10 would the other remaining portion of the manual
11 consist of?

12 A. Well, again, it can have to do with areas
13 and issues that may have to do with motivational
14 aspects of programming but not necessarily are
15 grounded in empirical evidence as such.

16 Again, this is a new area. This is an
17 area where there's a lot of -- some practice that is
18 done that seems to be in the right direction, but
19 cannot be supported with -- empirically grounded at
20 this point. So we did not address that, because the
21 theory manual did -- the treatment manual did
22 highlight that more specifically than here in 2011
23 from this report. And, again, I'm speaking now to
24 the first part of that sentence.

25 Q. Sure. And then moving on to the second

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1 part of that sentence, that about "50 percent of the
2 client treatment time is devoted to skill practice."

3 So that was one of the recommendations of
4 the group?

5 A. I think we've stated in, I don't know,
6 maybe the last three or four reports, that it falls
7 less than that. And I believe, in the last report,
8 we said a similar statement. There's been
9 improvement, but it still does not meet that
10 threshold that we had suggested. I think -- I think
11 we also state that some inconsistency in some places
12 and situations they were, and others they were not,
13 but it wasn't consistent.

14 Q. And why is that the target, 50 percent of
15 the time spent on skills practice?

16 A. Well, again, we're -- we're just drawing
17 from the general literature, the general literature
18 and the specific literature that has come out,
19 again, the criminology work. And that was, again,
20 stating sort of the preface of these reports, of the
21 "what works" literature that's come primarily out of
22 Canada, institutional treatment programming.

23 Q. And the "what works" programming, is that
24 the risk responsivity --

25 A. Yes.

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1 Q. -- model?

2 A. Yes. Yeah, the Andrews Bonta.

3 Q. And that's -- Is that standard modeled for
4 this type of treatment?

5 A. For institutional programming, yes.

6 Q. Are you aware of -- Are any of the other
7 programs that you evaluate or have evaluated, do
8 they use a different model?

9 A. No. For the most part, the risk/needs
10 response activity is pretty much standard
11 expectation within programming. That's the most
12 recent literature we have of research, anyway,
13 specific to what are critical elements in a change
14 process when working with offender populations.

15 Q. And in the next paragraph, it's talking
16 about the structure of the treatment and the hours
17 spent. And the conclusion there: "Consequently, we
18 recommend that the program increase the number of
19 treatment hours devoted to delivering services
20 according to the forthcoming structured skill base
21 psychoeducational model" -- "modules and increase
22 the number of group process hours" -- "process group
23 hours."

24 As far as you know, has that occurred?

25 A. I think what we -- Yeah, just so I can be

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1 clear: You're talking about the last part of that
2 where we said, "We recommend that the program
3 increase the number of treatment hours devoted to
4 delivering services to the forthcoming structured
5 skill psychoeducational module and decrease the
6 number of process group hours." Is that what you --

7 Q. Right.

8 A. Yes.

9 Q. And so has that happened?

10 A. Yes.

19 Do you -- Is MSOP, in your opinion,
20 providing enough opportunities for community
21 outings?

22 A. I'm not quite sure when you say "enough."
23 It's increased. It's increased from this particular
24 report, 2011 to 2013. It seems to be appropriate,
25 you know, the pace of involvement in the community

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1 of the -- Again, we're talking about this relatively
2 small program. But we didn't see anything out of
3 the ordinary of concern in that -- in that respect,
4 and that's why we didn't identify that as
5 problematic in our recent report in 2013.

6 Q. So for other programs that you evaluate,
7 or have evaluated, is there -- are there programs
8 that initiate things like community outings and more
9 interaction with society earlier on in the program?

10 A. I can't -- I mean, I can't speak
11 specifically anymore, I mean, because some of the
12 programs have been programs only that I saw a number
13 of years ago.

14 But, for the most part, this is generally
15 what you'll see when a person gets to this point, is
16 when you start the transition process to the
17 community. So this is -- this does not -- this is
18 not out of what you would expect in looking at civil
19 commitment programs.

20 Q. And my understanding is that, in the past,
21 and this is -- this is some years ago, maybe before
22 you were associated or affiliated with the program,
23 but there was more, particularly on the St. Peter
24 campus, patients even in phase 2 had more
25 opportunities to go off campus and interact with

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1 people outside a secure perimeter.

2 Is that something you see as beneficial to
3 treatment?

4 A. Integration in the community is
5 beneficial, yes.

6 Q. And this has become an issue recently
7 about some of these people who go from spending a
8 fairly lengthy time in prison and then a fairly
9 lengthy time in the MSOP program, so that they've --
10 you know, some people have spent a good portion of
11 their life within some sort of institution.

12 A. Right.

13 Q. Would it be beneficial to help people
14 reintegrate into life after MSOP by initiating some
15 of these opportunities earlier?

16 A. It may.

17 Q. Do you see a possible negative therapeutic
18 impact on having these opportunities early in the
19 program, like I said, in phase 2 at one time, and
20 then have those opportunities retracted across the
21 board for people in phase 2?

22 A. In other words, just so I'm clear, you're
23 saying: Was it detrimental to them to have some of
24 these privileges and then have them removed? I
25 think that's always a disruptive kind of thing when

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1 you have certain freedoms and opportunities and then
2 those are changed.

15 Q. BY MR. GOODWIN: Well, currently -- we'll
16 start there -- do you see a problem with a hostility
17 between staff and clients at the MSOP?

18 A. No. Well, I take that back.

19 Certainly, there's some hostility towards
20 the program by clients, because of the very issues
21 that we're talking about. But, no, I don't
22 generally see a hostility between -- on a personal
23 level, between staff and clients.

24 Q. When you've had meetings with clients as
25 part of the annual evaluations, has this been an

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1 issue that you recall coming up?

2 A. Not that specifically. Issues were
3 different.

4 Q. What -- When you have had these meetings,
5 what were some of the issues that did come up, that
6 struck you as concerns from the clients?

7 A. Well, they sort of ranged. One was, you
8 know, why can't we have the number of things we used
9 to have? And so it had to do with just general
10 privileges within an institutional setting. So
11 that's one.

12 And the other thing is just sort of the
13 overarching concern, and that is: Nobody gets out
14 of this place. And that's, I think, what we've
15 shared in all the reports, that it's -- this is the
16 predominant issue of everyone, is that, "Why do
17 anything? Nothing happens."

18 Q. And that actually leads into this next --
19 the last paragraph starting on that page: "Although
20 the program has made strides in preparing clients
21 for discharge, none have yet been discharged. This
22 is partly due to the slow movement through the
23 program and the multiple legislatively required
24 steps for discharge in Minnesota. The lack of
25 anyone getting out can be demoralizing to clients

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1 and staff, and, in the long-term, will likely
2 increase security concerns."

3 Do you still agree with that statement?

4 A. Yes.

5 Q. And what -- when you said "this can
6 increase security concerns," what do you mean by
7 that?

8 A. Well, when people become hopeless in a
9 process, they start reacting within the environment
10 they're in; and so -- because of frustration and
11 anger and what have you. And so it's pretty common,
12 when people don't have a sense of movement or change
13 or opportunity, that they start acting that
14 frustration out.

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5 Q. Okay. And if you'd turn to page 9 of
6 eleven, there's the service documentation is the
7 topic and it's talking about the documentation in
8 the client records. And in here, the final
9 sentence: "Several of the records of the treatment
10 group progress reviews were limited in content
11 regarding examples that indicated progress by the
12 client."

13 Is that -- Is that still a concern, the
14 amount of documentation of client progress at MSOP?

15 A. In one area, there's -- The one area
16 that's part of this -- that comment is -- has
17 improved, and that is to -- that the progress
18 itself, how it's documented mainly, because the
19 matrixes are clearer, the behavioral descriptions
20 are clearer, and therefore the documentation
21 reflects that.

22 What is not still reflected, and is in our
23 2013 as well as, I think, our 2012 report, is --
24 what isn't documented as clearly as we would suggest
25 as to what those barriers are, why they're not

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1 moving and what is being done about it.

12 Q. Generally, my understanding, and correct
13 me if I'm wrong, is that, you know, if there's an
14 incident where someone's acting out of line, they --
15 there's a series of major/minor redirection. These
16 are things that go in someone's file to show that
17 they're falling -- I think it's "behavioral
18 control," is the term is used.

19 Are you aware of any system in MSOP -- So
20 I guess the point I'm making is: These generally
21 reflect negative behavior; is that fair to say?

22 A. Yes.

23 Q. Are you familiar with any sort of system
24 in MSOP that reflects achievements, or sort of a
25 counter to that, where you're saying, "Hey, this

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1 person's" -- "You get a gold star," something to
2 that effect?

3 A. Yeah --

4 MR. GOODWIN: Your microphone just fell.

5 THE VIDEOGRAPHER: You lost your mike.

6 Thank you, sir.

7 THE WITNESS: Not specific, you know, like
8 a report that's a standalone; but it is -- it
9 certainly is embedded within the documentation of
10 progress reviews, and those are reviewed during
11 their quarterly meetings.

12 Q. BY MR. GOODWIN: Well, is it a concern
13 that you have this full system for recognizing and
14 correcting negative behavior, but the positive
15 behavior, it sounds like, is primarily recognized in
16 the treatment records; and then if there's a
17 concurrent lack of records in the treatment, is it
18 -- is there a concern that the negative issues are
19 more identifiable than -- than any positive behavior
20 that's been exhibited by a client?

21 A. It could be. And that's why -- that's why
22 we asked questions about the BER system. It's out
23 of those questions we asked, is why the MSOP -- and
24 I think it was in, again, the '12 or '13 report they
25 did a review of their BERs as to what is the impact,

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1 who's receiving them, how frequently are they being
2 used, what have you, so to bring greater attention
3 to that issue.

4 It's also why we looked at that in the --
5 when we did the program on phase progression to see,
6 are BERs part of the process that's getting in the
7 way of people progressing? In other words, are they
8 getting an inordinate amount of attention that is
9 creating a problem?

10 So we have -- we have looked at those
11 issues. In looking at those particular issues,
12 there was nothing that seemed to indicate -- and
13 that's why we did not state that, specifically to
14 the fact that they seemed to create an inordinate
15 barrier to the process. But it's certainly
16 something one always has, and that's why we've
17 highlighted it, that the program has to continue to
18 look at that BERs don't take and get that kind of
19 attention that could have that kind of impact. But
20 it has been looked at and it has been addressed, and
21 MSOP has been looking at it as to, you know, what is
22 the general impact of BERs.

23 So that's as far as we've gone with
24 reviewing that up to this point. Again, it's been
25 only a recent move to where we've been looking at it

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1 in the past two to three years.

2 Q. Maybe to step back for some perspective:
3 Is -- Are the recommendations you make, is there any
4 obligation for MSOP to follow, or are these
5 advisory?

6 A. Totally advisory.

7 Q. Are you aware of any agency or entity
8 outside of MSOP, that provides direction to MSOP,
9 that they're compelled to respond to?

10 A. None other than -- and, again, I don't
11 know the specifics -- there is some licensure
12 requirements as an institutional setting; and what
13 the specifics of that is, I'm not sure. Of course
14 this -- these reports also become public record; so,
15 again, how they're utilized within, you know, other
16 parts of the agencies, I can't speak to.

17 Q. Okay. Well, just to turn towards the last
18 -- or page 10 of eleven here. Actually, sorry, it
19 starts off on the bottom of page 9 of eleven.

20 "Over the past few years, there was a
21 shift increasing security procedures, client
22 restrictions, and security staff having more
23 exclusive" -- "having a more exclusive role. During
24 this site visit, there was a noticeable increase in
25 discussions and actions being taken to balance

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1 security needs with clients' treatment needs."

2 And, as far as you're aware, have there
3 been any changes that have resulted from these
4 discussions --

5 A. Yes.

6 Q. -- about --

7 A. Sorry.

8 Q. -- just about balancing security and
9 treatment?

10 A. Yes.

11 Q. And what are some of those?

12 A. Again, it's hard for me to just be
13 specific, other than I know that there's been a
14 number of just rules, regulations, expectations that
15 have changed, that, again, have softened -- softened
16 the environment as to -- Also, there's been a
17 significant change in the level of movement that
18 people can have within the setting, going from one
19 place to the other without being restricted or
20 having staff escort.

21 So, yeah, there's been a very noticeable
22 change in the reduction of what -- you know, of
23 restrictions and rule policy that was not necessary,
24 and there has been increased movement.

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9 (Exhibit 4 marked.)

10 Q. BY MR. GOODWIN: Okay. Are you familiar
11 with this document?

12 A. Yeah, generally.

13 Q. And if you would -- Now, this is the full
14 annual report.

15 A. Right.

16 Q. And if you'd turn to page 35, this is the
17 appendix. Again, it looks like this was authored by
18 you, Robert McGrath, and William Murphy?

19 A. Yes.

23 Q. And the date of report was -- was January
24 7th, 2014; is that --

25 A. Yes.

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1 Q. -- your -- accurate?

2 So prior to -- Do you submit this report
3 to -- Does it go to -- Who does it go to when you're
4 done with it?

5 A. We send this report to the -- to the
6 clinical director and executive director.

7 Q. And prior to them getting the report, do
8 they have input on the -- on the report as you're
9 drafting it?

10 A. They have input, yes.

11 Q. Do they review drafts of it?

12 A. Well, how the process works is this, is
13 that once we have done the report -- We want to make
14 sure that the report reflects accurately. The
15 people want basic things, basic -- the names of
16 individuals, titles, dates, sometimes the particular
17 numbers that we have taken from them and that we
18 want to make clear: Is that what the number is? So
19 it's those types of edits that we ask for. What we
20 don't do is solicit or respond to changes of any
21 kind of content of the reports. That's the
22 expectation we have, as well as they well
23 understand.

24 And so, yes, they do see the draft; and,
25 yes, they can give input as to edits, which usually

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1 are quite infrequent; but they do review it prior to
2 us completing it.

3 Q. So for this 2013 report, do you recall if
4 -- So that would be Jannine Hébert and Nancy
5 Johnston who would review it?

6 A. Yes.

7 Q. Do you -- Do you recall if either one of
8 them had any edits to the document?

9 A. You know, I can't remember for sure. That
10 would have to be a question, I think, shared with --
11 because I think the final review edit of this was
12 with Bob McGrath, Robert McGrath, but it would be
13 very -- it would have been of very small edits;
14 otherwise, we would have had a meeting about that,
15 in any way -- which, again, I -- we've never come
16 across in the seven years; but it would have to be
17 very, again, "typo" type of edits.

18 Q. Okay. And at the bottom of the first page
19 here, under the summary of findings, the last full
20 paragraph: "MSOP, however, is responsible for
21 providing timely and effective treatment designed to
22 help clients reduce their risk to sexually reoffend
23 and reintegrate back into the community."

24 Is that -- Do you agree with that
25 statement still?

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1 A. Yes.

2 Q. Do you think that MSOP is providing
3 effective treatment to satisfy that?

4 A. Yes.

5 Q. And how -- how is that possible if
6 nobody's actually been reintegrated?

7 A. Well, because treatment and movement is
8 two different things that have different variables
9 involved. And, as we've shared in other reports,
10 there's a number of things that MSOP could do that
11 we feel could address this issue of slow movement,
12 as well as we've addressed the issue that there's
13 also external issues that are affecting the
14 movement.

15 So the components of the treatment, the
16 model of the treatment, in most part, is intact as a
17 program that has capacity to move people; but then
18 there's these barriers as to why the movement isn't
19 happening. So I'm separating the treatment from
20 progress.

21 Q. So for some of these things where it's
22 been recurring issues, you know, that have been
23 raised periodically and regularly in the annual
24 evaluation reports you've written, is: After having
25 done this for a number of years, is MSOP responsive

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1 to these reports?

2 A. They have been.

3 Q. And in what ways?

4 A. Well, I'm saying, if you take a look at
5 all of the different things we recommend, has there
6 been any progress in those areas? Or in some of
7 those areas we've made the suggestion but no
8 attention was either drawn to it or any change made?
9 That would be pretty rare. In fact, it's hard for
10 me, because we always go back to the very things we
11 made suggestions and recommendations about, to see
12 if something's happened.

13 Now, one could raise the issue: Is it
14 happening fast enough? That's another -- it would
15 be a separate issue. But they have been very
16 responsive to all of our recommendations, and I
17 can't think or point to a situation to where we made
18 a recommendation, that they didn't give some
19 additional attention to on our follow-up from
20 between that and the next follow-up evaluation.

21 Q. Well, to get back to the point you just
22 made: Do you think the changes are happening fast
23 enough?

24 A. No.

25 Q. If -- What do you think is the most

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1 important change that you would like to see, that is
2 not happening fast enough?

3 A. You're talking about within MSOP?

4 Q. Right.

5 A. Within MSOP, I think a mechanism or a
6 system to identify barriers of progress so that
7 there can be a more specific and timely response to
8 that. And we've recommended that in our last two
9 reports and, I believe, also in a phase progression
10 evaluation that we did last year in February.

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10 Q. Well, given that the growth at Moose Lake
11 and the chronic problems with getting full
12 employment there, do you think the combination of
13 growing a client base and a limited pool of staff to
14 fill the positions there has compromised the
15 treatment at Moose Lake?

16 A. I think it's had an impact, yes. And we
17 stated that in our reports, that we feel that that
18 may be limiting, because -- I think we shared in one
19 report how some of the comments of clients as well
20 as staff shared that it's difficult to work through
21 some of the issues because the group sizes were
22 larger and what have you, because, again, of lack of
23 staffing. So it seems totally reasonable that --
24 that it would be part of the problem, yes.

25 Q. And so that impact, is that a negative

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1 impact on the treatment program?

2 A. Yeah. Not having adequate staff to
3 deliver the services is.

4 Q. And are you concerned that that is holding
5 back patient progress through the program?

6 A. Can't speak to it specifically, point to a
7 causal relationship; but I think that it's another
8 issue or a barrier that one has to overcome, that
9 can impact progress.

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3 Q. BY MR. GOODWIN: Well, looking at the
4 documents reviewed and the individuals contacted
5 about your analysis of the program, outside of the
6 clients that you've interviewed, is it -- is it fair
7 to say that the source of your information comes
8 from MSOP?

9 A. Yes.

18 Q. Okay. And then under that same
19 "procedures" section, towards the bottom, it's
20 talking about -- there's -- three lines up from the
21 bottom: "Attended the following treatment groups"
22 -- I guess it's four lines up. It says: "No
23 treatment or psychoeducational groups were held at
24 St. Peter during the visit, as it was a modified
25 programming week and these groups were not held."

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1 Do you see that at the bottom of the --
2 page 36?

3 A. Bottom of page 36?

4 Q. Just -- Just the point about there was no
5 program because it was a modified programming week
6 at St. Peter.

7 A. Right. Right. Okay.

8 Q. What is a modified programming week?

9 A. What it means is, it's actually something
10 that we had -- I'm not sure if we had put it in a
11 report, but we had discussions about what to do to
12 allow people to have breaks in between various
13 psychoeducational programming; that the intensity of
14 people being in programming nonstop, not having
15 breaks, can be problematic. It also gives an
16 opportunity by having breaks so people can do
17 paperwork, what have you, to catch up, rethink as to
18 what they want to do next, but at the same time to
19 not have as sort of a time-out -- because these
20 folks are there and they need to have continued
21 attention to their needs, therefore to develop what
22 we call modified programming.

23 So that's what this is: Instead of the
24 right -- the tradition -- the typical training that
25 we have, they have these modified programming

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1 periods of time, relatively brief periods of time,
2 to where it's still providing a treatment focus but
3 it's just doing it in a different kind of way.

4 Q. And so how -- If you were a patient in the
5 MSOP program during a modified programming week, how
6 -- how would it look different than a regular
7 programming week?

8 A. It can vary in a bunch of different ways.
9 Some of the things that are done is doing things as
10 a group, full group, larger group activities, group
11 activities that have particular attention to
12 anywhere from motivational kinds of focus to
13 enhancing the treatment culture, to actually
14 providing specific kind of information, or having
15 served show-and-tells so people are sharing
16 information from the things they've learned from the
17 previous period of time.

18 So there's a lot of different ways you can
19 do modified programming. I know they've done it --
20 done it in a number of different ways. We've sat in
21 on some of that programming to see if it's actually
22 grounded and, from a therapeutic perspective,
23 providing a service. And we feel that it is. But
24 that's the value of it: It's trying provide a break
25 for people from the routine, as well as opportunity

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1 for people to sort of refuel until they go into the
2 next segment.

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25

Q. And as part of your evaluation of the

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1 program, do you attend or do you go to all the
2 units? By that, I mean there's -- there's the
3 conventional treatment units and then there's the
4 alternative units; but then there's also the young
5 adult unit, there's the NOVA unit for high mental
6 illness people, and the -- I think it's beta unit
7 for geriatric and, I think, physically disabled
8 people.

9 Is that -- Is that part of your --

10 A. Yes.

11 Q. -- review?

12 A. We try to -- We go to all the different
13 settings. As to how much time or what we do in
14 those settings kind of depends from what we've seen
15 from the year before to see if we need to follow up
16 our concern in particular areas we want to visit.

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4 Q. And, also, in talking between these
5 facilities, I also want to make note: You said you
6 paid particular attention to omega units at Moose
7 Lake. And omega units, I think, are described as
8 behavioral therapy units where -- Maybe, can you
9 describe what "omega unit" means to you?

10 A. Well, yeah. This is, again, dealing with
11 persons that are highly disruptive to the
12 environment and which may be generated either from
13 just reaction to not wanting to comply with issues,
14 to persons who are having other types of significant
15 health or mental health issues. And so omega units,
16 then, is a place to provide sort of a time-out for
17 the individual, as well as focused support and
18 treatment to get them stabilized so they can go back
19 into the -- back to their parent units.

20 Q. And so why did -- why did that require
21 particular attention, in your mind?

22 A. This is an area where I maybe provide
23 additional attention to; because working with
24 special needs populations, these are the folks that
25 oftentimes are most vulnerable, in vulnerable

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1 situations; they're in more isolated type of
2 situations. So as to what is happening in those
3 types of settings, it is usually something that I
4 think we're quite sensitive about. We're sensitive
5 to the fact that persons who are highly disruptive
6 might end up in sort of dead-end situations or what
7 we might call a back-ward situation. So we're --
8 we're -- we put a great deal of attention to make
9 sure that people don't fall through the cracks in
10 that regard.

11 Q. And since you've been analyzing or
12 reviewing the MSOP program over the years, have you
13 seen a change in how the omega unit is handled?

14 A. Actually, it's very -- they do an
15 impressive job. They really -- From what I've seen
16 in many places, they -- part of it is because
17 they've got some very good people working in those
18 settings, the people that are in charge of those
19 particular units.

20 The other thing is we had asked them to
21 put together sort of a protocol procedure as to how
22 you evaluate as to when they get there, as well as
23 to get them back and get people back in a timely way
24 and to reintegrate them effectively to the parent
25 units again; and they responded to all of our

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1 recommendations.

2 And so, yes. But that's why we keep
3 attention to that area; it's what we call a
4 high-risk area for neglect.

5 Q. And as you've been looking at the MSOP
6 program over the years, have you seen it -- have
7 there been incidents that have raised concern about
8 neglect in the omega unit?

9 A. There hasn't been. The only issue I think
10 we've raised in any report was from 2011, I think,
11 to '12 -- or was it '12 to '13 -- that they didn't
12 have as much staffing, so they couldn't do as much
13 individualized counseling as they had done before.
14 We were concerned about that; but, at the same time,
15 because of the very skilled staff they have in those
16 units, we've saw that, again, adequate and
17 appropriate treatment was still being provided, but
18 our concern was that -- to not continue in a setting
19 of understaffing in those; and, again, it's stated
20 in one of the last two reports, I know.

21 Q. And for those omega units, are they
22 individual units as opposed to are they -- How many
23 people are in any given omega cell?

24 A. I can't say for certain. They are
25 separate, they are separate structures. They're all

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1 within the same pod area, but they are separate.

2 I'm trying to think. I think the most restrictive
3 area maybe has about four or five living quarters.

4 Q. But that in each living unit -- That's
5 just for one person; right? They're --

6 A. In the area that is the most restrictive,
7 they have a place where a person can be fully
8 isolated, as well as another area where they may
9 have three or four persons. So I can't remember the
10 exact number of beds, but they have the full
11 continuum of what we'd call safety precautions that
12 they can -- they can introduce, from a person being
13 totally removed from other individuals, to where
14 they're also in highly supervised small environment,
15 small population units.

16 Q. Well, I guess the question I'm getting at
17 is: In general, most patients in the MSOP program
18 are double bunked and have a roommate. But the
19 omega unit, as I understand it, are those people
20 double bunked in omega units, or are they --

21 A. No.

22 Q. Do they have their own -- They don't.

23 And is there -- What is the time line? Is
24 there a set time line for how long a person is in
25 omega, as far as you've seen?

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1 A. Again, I can't speak. I'm sort of
2 guessing from memory, but there is some kind of
3 protocol review. They're looking usually within,
4 you know, days, weeks; and certainly 30 days is sort
5 of what would be sort of outer limit. There's some
6 people who might be there longer; but, no, they're
7 very conscious about quick movement. And there has
8 been continued active recycling, moving people
9 through those units; so they're not -- clients are

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7 Q. Okay. And for the next point, for
8 responsivity, the second sentence there: "Programs
9 should consider responsivity issues such as clients'
10 motivation, intelligence, psychopathy, mental
11 illness, and cultural issues."

12 Do you think that MSOP adequately does
13 that?

14 A. Yes.

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3 Q. Sure. In relation to the alternative
4 program, has the MSOP adequately adjusted the
5 program to present it in a way that an individual in
6 the alternative program can understand it and
7 complete the program?

8 A. I guess I can't say it as an absolute.
9 There's been continued improvement in that -- in
10 that regard.

11 Q. Well, do you -- do you see the program, as
12 it's structured now, as a -- as a barrier to someone
13 who was -- who might be in the alternative program
14 with intellectual disabilities?

15 A. Are we talking now specifically to the
16 materials as to the responsivity issue itself?

17 Q. Yes.

18 A. I don't see it as significant, a
19 significant barrier to what could be getting in the
20 way of movement.

21 Q. Well, if it's -- if the program -- if the
22 program, as it's structured and delivered, is not a
23 barrier, what would be a barrier to movement within
24 the alternative program?

25 MR. IKEDA: Object to the form. Vague.

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1 Speculative.

2 Q. BY MR. GOODWIN: You can answer.

3 A. Well, I can only say, specific as to the
4 barriers to movement, again, are articulated in the
5 progress evaluation report that -- that I support;
6 and those recommendations were very specific to
7 phase progression and what we saw as the barriers to
8 those. Again, I -- we can review those, but I'd be
9 guessing to go from memory what we stated; but we
10 identified rather specifically what we saw as the --
11 what was inhibiting the progress of clients.

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10 Q. And the next sentence is: "The program
11 also needs to ensure that factors considered for
12 program movement are related to risk to reoffend."

13 Is -- Is that a concern, that there are
14 factors that are considered, that aren't related to
15 risk to re --

16 A. Is this --

17 Q. Sorry. The last sentence of page 39.

18 A. Okay. So what is the question, then, with
19 39?

20 Q. So the sentence says: "The program also
21 needs to ensure that factors considered for program
22 movement are related to risk to reoffend."

23 By the fact that you and your group raised
24 this issue, is that a concern that there are factors
25 that are being considered, that aren't related to

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1 risk to reoffend?

2 A. It's a concern that maybe.

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8 Q. And so is there a difference in how you
9 approach the treatment model in a facility like
10 MSOP, as opposed to something that is explicitly a
11 correctional facility?

12 A. Not in terms of working with the
13 theoretical treatment model that you would use the
14 delivery of services to provide best practice. It
15 should look the same.

16 Q. Okay. And if you move down the last
17 paragraph of that section: "Our review of treatment
18 records, staff interviews, and group observations at
19 both sites indicated that use of skill, teaching,
20 and practice in core and psychoeducation groups was
21 very infrequent."

22 Is -- Is that an accurate observation?

23 A. Yes.

24 Q. And is that a concern?

25 A. Yes.

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7 Q. Okay. And then for the program monitoring
8 and evaluation, the third paragraph there: "In our
9 last report, we recommended that the program
10 consider whether the risk management committee
11 should focus on reviewing progress from phase 3 to
12 CPS rather than from phase 2 to phase 3."

13 Why did you make that recommendation?

14 A. We made that recommendation, first of all,
15 not based on that we could see that it was creating
16 a problem of movement. We raised the issue because
17 of our concern that anytime you raise another level
18 of review, that that can create just another
19 inherent boundary to movement. And so we cautioned
20 as to why you want to increase -- have another
21 review process, because of the potential that it
22 could create.

23 Q. And the last paragraph there, this talks
24 about the concern about people not moving through
25 different phases in a timely fashion.

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1 Do you know if MSOP has -- has responded
2 to this concern raised here?

3 A. Which particular concern?

4 Q. So it's -- So starting with the first
5 sentence there: "Although there is increased
6 movement between phases, we recommend, as we did
7 last year, that a formal system be developed to
8 clinically review those clients who, in a reasonable
9 period, are failing to progress between phases."

10 A. They were in the process in our
11 discussions of creating a more formal approach.
12 Informally, they were addressing those issues now
13 more in the quarterly meetings as to what was
14 getting in the way. We also saw it in some
15 documentation. But as to a consistent formal system
16 across programming, that was not yet present.

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7 Q. In the third paragraph from the bottom,
8 it's talking about clinical supervisors and
9 supervision of the clinical treatment. And partway
10 through that paragraph, it states: "However,
11 supervisors rarely conduct direct observation of
12 staff leading groups."

13 And is that -- is that accurate as far as
14 you know?

15 A. Yes.

16 Q. And is that a concern for you?

17 A. Yes.

18 Q. And do you know why there has been limited
19 amount of supervision observing the actual group
20 therapy?

21 A. I can share the response to that is that
22 it is the intent and what is the expectation of the
23 program to actually do that; but it would be kind of
24 -- again, because of staffing shortages, which
25 allows a person with that time. Because they're

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1 trying to maintain with the shortage of staff to
2 make sure they're still providing the treatment
3 hours; and to provide -- take -- move those hours to
4 more supervision hours means they could have a
5 direct impact on the actual services, delivery of
6 services. So that's why it's not happened, is what
7 -- is what they shared with us.

8 Q. So, as you understand it, the reason there
9 has been -- not been this supervision of group
10 therapy is, is it fair to say, it's just a staffing
11 issue with having adequate --

12 A. That seems to be, since there's an intent
13 to do it and everyone's supported doing it and
14 everyone that we've talked to, from administrative
15 to clinical, but yet it's not happening. And it
16 seemed -- the only thing that really seemed to make
17 most sense was that it's the logistics.

18 Q. And what is the concern about not having
19 the supervisors directly observe the group?

20 A. One, that you're going to get clinical
21 drift, people doing their own thing, in a sense.
22 There's -- It reduces the consistency of programs
23 across programs. It also reduces the amount of
24 feedback for facilitators to become more effective
25 at what they're doing.

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6 Q. Well, in that -- in that same sentence, it
7 says: "Overall, staff were positive about the more
8 open movement."

9 Did you -- Did you have any discussion
10 with -- with clients about their perception of the
11 AMS system?

12 A. There was, there was some. And aside from
13 sometimes a person saying, you know, "I'm in a
14 prison; they treat me like a prisoner" -- because,
15 again, we're trying to look at themes. The theme
16 that seemed to be more impactful was: Everyone was
17 pleased that there was more movement.

18 Q. And has that -- So what has been your
19 general view of the AMS system as to how it's
20 affected the Moose Lake?

21 A. Our initial reaction to it was somewhat
22 skeptical, and we were rather pleased to see that it
23 seemed to actually bring about the effects that
24 we're -- that everyone was looking for; and that was
25 that, rather than just another way of trying to have

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1 tight security, that in fact it was reinforcing and
2 enhancing movement within the system. We were very
3 skeptical whether that would take place; and we were
4 quite pleased, quite frankly, to see, you know, that
5 was the case. That was the first time I had
6 experienced working with that system and good
7 results, from first blush anyway.

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22 Q. BY MR. GOODWIN: Okay. I just have a
23 couple brief questions to follow up with.

24 First of all, about the campus arrangement
25 for MSOP, the fact that there's a part of the

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1 program in Moose Lake and part of the program in
2 St. Peter's, is that a concern? I know it's come up
3 as far as having consistent treatment from campus to
4 campus; but, overall, the structure of the program,
5 to have two distinct campuses like that, is that a
6 concern for you?

7 A. Not necessarily. It can have as many
8 advantages as disadvantages; so, no, I -- I think it
9 can be done. There's a logistics, like you said,
10 consistency; but also advantages of having another
11 place that people can go to and...

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13 Q. And we haven't spent much time talking
14 about it today, but I wanted to address the group of
15 the juvenile offenders or the young adult offender
16 group.

17 In your opinion, is it proper to
18 indefinitely civilly commit an individual who has no
19 adult criminal record?

20 A. I really don't have a response to that.
21 Usually, issues around adolescent histories and
22 juvenile issues, I usually defer to William Murphy,
23 who has had extensive -- extensive experience in
24 that area over many years.

25 So, as evaluators, we sort of bring

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1 certain areas of focus of expertise, and that's why
2 the three of us work together. And this is --
3 that's his area of expertise.

4 Q. Well, given that's his area of expertise,
5 has he ever raised concerns, in your discussions
6 with you and the other evaluators, about -- about
7 the fact that there are people who are civilly
8 committed indefinitely, who have no adult
9 convictions?

10 A. I can't recall, because -- On the other
11 hand, I can't recall that we were even aware that
12 there's individuals there that only had adolescent
13 history.

14 Q. Now that you know that there are
15 individuals who have no adult criminal convictions,
16 that are indefinitely committed to the MSOP program,
17 is that a concern that you plan on addressing in the
18 next evaluation?

19 A. That would raise -- That would raise a
20 concern. Again, our evaluation, we're looking at
21 larger themes of issues, versus individual clients;
22 but if that is part of a process, that would be an
23 area of concern, yes.

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6 Q. And outside of the roadblocks and the
7 release of patients, as far as the court process and
8 the legal steps to get out of the MSOP, in your
9 experience, having spent some time there, do you see
10 individuals, either people you formally or
11 informally interviewed, where you said, "This person
12 doesn't belong in a confined situation like this, in
13 a high security civil commitment"?

14 A. No, never specifically to a client -- I
15 mean, about a particular client. I know we're sort
16 of looking in broader terms, our concern: Because
17 of the way the system -- the structure is set up for
18 movement, that persons could end up being stymied
19 from that process. And, again, that's reflected, I
20 think, in all our reports in that regard.

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24 Q. BY MR. GOODWIN: Well, in your mind, is it
25 possible to complete the MSOP program?

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1 A. Again, as to -- and what you -- how are
2 you defining "complete the program"?

3 Q. How would you define it?

4 A. It depends -- The program, to me, it would
5 be the ability to move people through, into the
6 provisional -- through the provisional discharge
7 process. And so that -- that, to me, is the -- is
8 what you're trying to accomplish. And as we've
9 stated before, few people are getting to that point,
10 and that's problematic.

23 Q. Is it -- As far as you know, will MSOP
24 support a petition for full or provisional discharge
25 from the program if a patient has not completed the

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1 treatment program?

2 A. I'm not sure; because, again, it gets back
3 to: What is completion of the program? Because we
4 looked at situations like the folks that were going
5 to move to Cambridge. There's -- There's some
6 variance as to what "completion" actually means, and
7 I think that has -- attention has been given to
8 that.

9 As to whether -- what that line is now or
10 what that criteria is, at this time, I really -- I
11 don't have specifics, what that would be at this
12 point.

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8 Q. Well, looking at other programs you've
9 evaluated, are there -- do they contain sort of a
10 completion where you can say, "Okay. Here are the
11 objective measures. I've" -- "I've done A, B, C, D.
12 I've met the requirements and I'm done with this
13 program"?

14 A. Yes, similar to MSOP. In other words,
15 that's what the matrix system is: Have they met the
16 criteria? And the matrix system is that criteria,
17 the matrix scoring.

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19 Q. And in -- Is it accurate to say that --
20 Well, let's talk about the program as it exists now.

21 Is it your opinion that the program
22 operates consistent with best practices?

23 A. Yes.

24 Q. And, in fact, in your reports, you say
25 that you evaluated the program against international

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1 best practice standards and guidelines in the field;
2 is that correct?

3 A. Yes.

4 Q. And, in your reports, you found that MSOP
5 was indeed operating the program consistent with
6 those standards and best practice and guidelines;
7 right?

8 A. Yes.

9 Q. And that's a conclusion that the three of
10 you reached unanimously; is that right?

11 A. Yes.

12 Q. Now, one of the things that Mr. Goodwin
13 asked you about was accreditation by the Joint
14 Commission.

15 Do you remember that area of inquiry?

16 A. Yes.

17 Q. Okay. And you had talked about how
18 they're -- they're really -- I don't know if you
19 said the word "impossible," but you said it was
20 difficult to come up with accreditation standards
21 for sex offender treatment program like MSOP; is
22 that correct?

23 A. I did.

24 Q. And if someone were sort of -- Or is there
25 an organization out there that -- that, you know,

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1 someone can look to, to figure out, you know, what
2 best practices might be?

3 A. I think the closest you can come to
4 accreditation process -- because there are
5 accreditation systems in Canada and in the U.K., and
6 so those are sort of the -- I would say, the most
7 useful guides that we have at this point.

8 Q. Well, in the United States, there's an
9 organization called the Association for the
10 Treatment of Sexual Abusers; is that right?

11 A. Yes.

12 Q. Now, is that one place that you would look
13 to?

14 A. Well, it's one place that we look to; but
15 it has more to do -- more specifically to, again,
16 practice standards and guidelines. It doesn't
17 necessarily speak specifically to structure of a
18 civil commitment program. But, yes, it does provide
19 -- in the field in general, it is the most
20 established standards of practice that we have in
21 the field.

22 Q. And I guess I've noticed in your reports
23 that you comment on the fact that there are a good
24 number of MSOP employees that attend the ATSA
25 conferences.

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1 A. Yes.

12 Q. Well, as Mr. Goodwin led you through a
13 couple of your prior reports -- specifically I'm
14 talking about Exhibits 2, 3, and 4 -- he pointed out
15 some sentences here and there in the report, where
16 you and the others made recommendations or
17 identified areas of concern.

18 Do you remember all of this testimony --

19 A. Yes.

20 Q. -- that just happened?

21 Is it fair to say that, notwithstanding
22 the issues that Mr. Goodwin has identified, you
23 know, in these sentences located within your longer
24 reports, that, notwithstanding those things, it's
25 still the three -- your opinion at least, that the

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1 program operates within best practices. Right?

2 A. Yes.

25 Q. Now, I know you testified about the other

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1 programs around the United States and around the
2 world, that you've evaluated.

3 Whenever you evaluate a program, have you
4 ever evaluated a program and said, "This is a
5 perfect program, there are no" -- "I have no
6 recommendations for improvement"?

7 A. No.

8 Q. It's fair to say, Mr. Haaven, in your
9 mind, for a program to operate within best
10 practices, it doesn't have to be absent any kind of
11 recommendation for improvement; correct?

12 A. Correct. In fact, I would go on to say
13 that to be within best practice is to have an
14 advisory component to where you're getting feedback
15 as to other areas to where there could be
16 potentially clinical drift or program drift in a way
17 that it could in any way potentially compromise the
18 integrity of the programming.

19 Q. So you actually -- If I understand your
20 testimony correctly, it's your position, Mr. Haaven,
21 that the fact that MSOP has brought the three of you
22 in to evaluate them on an annual basis is actually
23 consistent with best practices?

24 A. Yes.

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14 Q. How is phase 1 of the MSOP program
15 reflective of current research or experience or
16 practices in the field of sex offender treatment?

17 A. Again, it's -- it's -- it's -- it's
18 congruent with what is -- what the literature would
19 expect, and that is preparatory. You're trying to
20 identify, one, preparation of -- that the person is
21 treatment ready, in a sense. It's the phase of
22 motivation, the person identifying what their goals
23 might be and looking forward. So in that sense.
24 And that's why I think I clarified that it's more
25 than just compliance with the rules; that it's

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1 preparatory process and the person becoming engaged
2 in the treatment process, before you start moving
3 more specifically into sex offender specific focus.

4 Q. So, in your experience and your opinion,
5 is the treatment phase design at MSOP consistent
6 with other treatment program designs in other civil
7 commitment programs?

8 A. With the ones that I've observed, yes.

9 Q. What do you say to people who may argue
10 that they don't get any sex offender treatment in
11 phase 1 of the treatment program? Do you agree or
12 disagree with that statement?

13 A. I disagree.

14 Q. And why do you disagree, in your
15 professional opinion?

16 A. Well, because, again, I think sometimes
17 it's not clearly understood what phase 1 is, again.
18 It's preparation, it's motivation, it's engagement.
19 It's not necessarily learning specific skills how
20 not to offend; that's the next phase. But to move
21 into that phase without first having the person
22 prepared, motivated, and involved in the process, is
23 contraindicated.

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19 Q. And so when you said compare -- Your --
20 And so your testimony then, sir, is that the 84
21 percent treatment participation rate compares
22 favorably with other programs?

23 A. Other civil commitment programs.

24 Q. Broadly speaking -- I know that you have
25 some recommendations about skill building,

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1 psychodynamic approach, things like that; but,
2 broadly speaking, do you have -- do you see
3 significant problems with the program manual at
4 MSOP?

5 A. No.

6 Q. The theory manual at MSOP?

7 A. And, again, you're talking -- you're just
8 talking about significant concerns? No.

9 Q. With respect to the goal matrix, we talked
10 about the Likert scale and things like that, is --
11 is the goal matrix something you'd expect to see at
12 a program like MSOP?

13 A. Yes.

14 Q. And that goal matrix is, in your opinion,
15 professional opinion, consistent with best practices
16 in the field?

17 A. Yes.

18 Q. Throughout your report, the three of you
19 looked at 12 areas; right?

20 A. Um-hum. Yes.

21 Q. And how did you decide what those 12 areas
22 would be?

23 A. Again, those 12 areas that we're looking
24 at, we're drawing, again, from the literature and
25 worked in the "what works" literature, criminology

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1 literature.

2 Q. And I'm -- I'm going to ask you to just
3 speak for yourself: But when the -- when you're
4 looking at these 12 areas and you're saying the
5 program operates within best practices, what are you
6 judging that against?

7 A. Well, it's -- it's a range of things;
8 because, first of all, we have the criminology
9 literature: So within those areas of practice,
10 there's certain kind of general expectations. We
11 then look at more specific treatment strategy
12 practice standards, and that's where we utilize the
13 Association for Treatment of Sexual Abuser
14 standards, which are maybe the most recognized
15 standards in the field. The third area that we look
16 at is what do other civil commitment programs do, by
17 looking at the surveys from the civil commitment
18 programs as to level of service, participation, or a
19 range of things that they put out in their surveys,
20 so we have an idea. And then we also look at what
21 is general consensus within -- within the field
22 itself. And the fourth thing is from our own
23 observations of other -- comparing it to other
24 programs. So that's really kind of the basis.

25 I -- There's really only one other piece

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1 to this, and that's the important piece, and that's
2 our familiarity with the accreditation process of
3 programs like this, which are in the U.K. Again,
4 Robert McGrath and William Murphy have been
5 specifically contracted and worked with the
6 accreditation system in the U.K. I have worked as a
7 consultant in special needs process in getting their
8 adapted programs up to meeting accreditation
9 standards. So we have that familiarity also with
10 accreditation system, so that's where we draw from.

14 Over the last six, seven, or eight times
15 you've reviewed the MSOP program, each time you
16 spend a day or two in St. Peter and a day or two in
17 Moose Lake; right?

18 A. Yes.

19 Q. And so you consider yourself familiar with
20 the physical plant of both facilities?

21 A. Yes. We're provided a tour, as well as we
22 make requests to see particular areas. So, yes,
23 we're very familiar with all of the plant area.

24 Q. And you're familiar that, with respect to
25 phase progression -- whether it's phase 1, phase 2,

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1 phase 3, or even CPS -- that there are different
2 levels of liberty, for lack of a better term that I
3 can think of off the top of my head, among those
4 groups of clients at MSOP. Is that accurate to say?

5 A. Yes.

6 Q. And so the complaints, say, from someone
7 who's in phase 1 at MSOP about their liberty and the
8 rules they live by would be different than someone
9 who lives at CPS. Is that fair to say?

10 A. Yes.

11 Q. And, in fact, one might expect that the
12 difference -- or that the complaints about liberty
13 and rules, and things of that nature, would be
14 different among someone who -- or between someone
15 who's at phase 1 at Moose Lake and even phase 2 or 3
16 at St. Peter; correct?

17 A. Yes.

18 Q. Going back to the goal matrix: In one of
19 your reports, you said something along the lines of
20 the goal matrix clearly links the key dynamic risk
21 factors that should be addressed in an effective sex
22 offender treatment program to MSOP's phases of
23 treatment.

24 Does that sound like a conclusion you
25 would have reached?

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1 A. Yes.

2 Q. And, I guess, in looking at your reports
3 and listening to your testimony in response to
4 Mr. Goodwin's questions, you -- it sounds to me that
5 the -- and so correct me if I'm wrong, but it sounds
6 to me that the concerns you have sort of deal with
7 the implementation of the goal matrix or how people
8 are being scored, for example?

9 A. Yeah. That was one of the concerns we
10 had, more significant concerns we had.

11 Q. But not necessarily with the structure of
12 the goal matrix, the structure of the goal matrix
13 itself?

14 A. That's a fair statement, yes.

15 Q. Is it accurate to say that you've actually
16 seen improvement in the area of concern that we just
17 talked about over the years?

18 A. The question was: Have we seen
19 improvement? Yes.

20 Q. Let's look at Exhibit 4, page 35, your --
21 your site visit report. And just for authentication
22 purposes, Mr. Haaven, why don't you page through to
23 the end and confirm for me that this is in fact your
24 report dated January 7th, 2014.

25 A. Yes, this is.

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1 Q. Well, with respect to program sequence, if
2 we look at page 39 through page 40, in that first
3 sentence, you note that "the overall program
4 sequence is logical and appears to be responsive to
5 clients' treatment needs and learning styles."

6 Is that accurate? To the best of your
7 knowledge as you sit here today, is that still
8 accurate?

9 A. Yes.

10 Q. And in several of your reports, you also
11 note -- you have praise for the recreation,
12 education, and vocational services program; right?

13 A. Yes.

14 Q. In fact, I think, in one of your reports,
15 you identified the vocational program as a "model
16 program and the strongest one we have seen in a
17 civil commitment program."

18 Does that sound familiar to you?

19 A. Yes.

20 Q. Is that still your opinion, as we sit here
21 today?

22 A. Yes.

23 Q. Give me a sense of what -- What's the
24 value of a recreation, education, and vocational
25 services program at a -- at the MSOP?

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1 A. A couple of things. One is, particularly
2 in institutional settings, you want to have an array
3 of diversional activities to, in a sense, sort of
4 provide a quality of life experience. It speaks,
5 again, to anyone that's involved in a treatment
6 program or a change process needs to have basic
7 needs in their life met; so the diversional aspect
8 is one important piece, again, for preparedness for
9 change.

10 The second part to that is that it gives
11 an opportunity to see how skills learned and the
12 treatment -- more specific treatment activities are
13 generalized to, again, more normative types of
14 behaviors and more disinhibited types of behaviors,
15 to see what effect the treatment might be having.

16 Q. Now, again, vocational services was one
17 that you pointed out as a model program in the
18 country.

19 What about vocational services in
20 particular at MSOP makes it a model program?

21 A. Well, one, most of the programs you see,
22 they're sort of doing -- making -- building widgets;
23 and it's -- and, instead, their program is actually
24 doing some really interesting contracts, meaningful
25 -- work that is seen as meaningful by the clients

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1 that are working in them. Their compensation, paid
2 compensation, the way it's done. Also the training
3 they receive. And, really, the kind of -- what we
4 saw as skill building within the vocational, beyond
5 just the skill itself, of how to get along with the
6 boss, how to develop work type of behaviors.

7 So we saw on many levels, from a
8 therapeutic perspective as well diversional
9 perspective as well as a skill opportunity
10 perspective, that they're actually learning some
11 marketable skills when hopefully they would get out.

12 Q. Is a vocational program, in your view, I
13 mean, is that part of a treatment -- a sex offender
14 treatment program?

15 A. We usually do not see it specified as one
16 of the components of a sex offender treatment
17 program, but yet it would be rare to find someone
18 working in our business that wouldn't say vocational
19 training is an important part -- which is sort of a
20 contradiction, in a sense, but in fact it's very
21 important.

22 Q. Because it teaches the skills that you
23 just talked about?

24 A. Right. And it's a generalizing of those
25 skills to a -- to a marketable profession. And

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1 especially working with men, to which much of their
2 identity is associated with their value and worth in
3 the workforce, it has -- it's a significant part of
4 the change process.

7 is what we've marked as Exhibit 6.

8 Do you recognize that document?

9 A. Yes.

10 Q. What is it?

11 A. It's, again, our site visit report from
12 2009.

13 Q. And is this the document that you and the
14 two others prepared?

15 A. Yes.

16 Q. If you look at page 4, in the second
17 paragraph, you'll note that there's some language
18 that says: "The program has been sensitive to
19 responsivity issues." Do you see that?

20 A. Yes.

21 Q. "The MSOP has developed specific programs
22 for those high in psychopathy, for young adult
23 offenders, for those with significant mental health
24 issues, and those with lower IQ and impaired
25 learning ability." Correct?

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1 A. Yes.

2 Q. Now, I know that was five years ago. Is
3 that still your opinion today?

4 A. Yes.

5 (Exhibit 7 marked.)

6 Q. BY MR. IKEDA: Mr. Haaven, in front of you
7 is what's been marked Exhibit 7.

8 Do you recognize that document?

9 A. Yes.

10 Q. And what is it?

11 A. It's our site visit report for 2010.

12 Q. And if you look at page 4 -- This is the
13 language that I asked about earlier, so...

14 "Since the last site visit, the program
15 has finalized and implemented the goal matrix for
16 phases 1, 2, and 3. This document clearly links the
17 key dynamic risk factors that should be addressed in
18 an effective sex offender treatment program to
19 MSOP's phasing" -- "phases of treatment."

20 Did I read that correctly?

21 A. Yes.

22 Q. And that is your opinion still today?

23 A. Yes.

24 Q. One of the things that you identified in
25 this report is you questioned whether two-hour group

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1 -- whether two hours of group sessions were
2 effective and appropriate for learning style.

3 Do you remember that --

4 A. Yes.

5 Q. -- in the alternative program?

6 A. Yes.

7 Q. Do you know whether MSOP has done anything
8 about that?

9 A. They reduced the length of the group time.

10 Q. You also, the three of you, opine in the
11 next paragraph on the use of the behavior therapy
12 unit and the high security unit. And you've
13 believed that, at least as to the high security
14 unit, length of stay was appropriate for the client
15 population in the MSOP.

16 That -- That is your conclusion; right?

17 A. Yes.

18 Q. In every year of your reviews, at least
19 going back to 2009, one of the -- We can move along.
20 You can put that Exhibit aside.

21 One of the things with respect to
22 administrative structure and program organization is
23 the three of you have consistently used language
24 that says "a strong administrative structure is in
25 place and processes ensure ongoing staff

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1 communication." Correct?

2 A. Yes.

3 Q. And so that's something -- a theme that
4 you saw throughout your reviews?

5 A. Yes. That's a area we give attention to.

6 Q. So fair to say that the -- Ms. Hébert is
7 the clinical director?

8 A. Yes.

9 Q. And she is one of the people that you
10 think is part of the strong administrative
11 structure?

12 A. Yes.

13 Q. And Nancy Johnston as well?

14 A. Yes.

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2 Q. With respect to the issue of community
3 outings, is it your testimony that one would expect
4 to see community outings happen around the time that
5 MS -- that it happens in MSOP's program?

6 A. Yes.

7 Q. So with respect to that issue, you think
8 that MSOP's policy is consistent with best
9 practices?

10 A. Yes.

11 Q. As part of your review, you've talked
12 about how you also review some client files; right?

13 A. Yes.

14 Q. And one of the things that you were asked
15 about earlier was, "Well, where" -- "Where would
16 someone find positive things about a client at
17 MSOP?"

18 Isn't it true, Mr. Haaven, that in fact
19 there are positive things that are said about
20 clients in progress notes?

21 A. Yes.

22 Q. And there are often positive things that
23 are said about clients in their quarterly and annual
24 treatment reports; right?

25 A. Yes.

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1 Q. When the three of you go to MSOP for your
2 site visits and to prepare your reports, your
3 testimony is that you have complete access to both
4 the facility and records?

5 A. Yes.

6 Q. Have you ever been denied access to a part
7 of MSOP when -- when you asked for it?

8 A. No.

9 Q. Have you ever been denied a file or a
10 record when you've asked for it?

11 A. No.

12 Q. And is it up to the three of you to
13 determine what to review?

14 A. Yes.

15 Q. What to write your report about?

16 A. The only end -- There's two parts: As to
17 what we're going to write our report about, included
18 in that report might be some specific questions that
19 they want us to respond to as problem areas that
20 they're having concern with, that we could give
21 additional consultation to. That would be the only
22 addition to what we're going to be reviewing.

23 Q. What do you think about that, the fact
24 that MSOP asks you to help them problem solve with
25 -- with these problem areas?

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1 A. Well, I think, every time that we've done
2 the debriefing with all staff afterwards, we share
3 with them that this is rather unique that somebody
4 would invite you in to snoop around in your back
5 yard and give you total access to find any dirt.
6 And so that's rather unique but also an important
7 piece of the programs like this; because you can
8 have drift in issues that can go, you know,
9 unaddressed. And so we try to certainly let the
10 program know that's a -- that's a very powerful kind
11 of intervention that they've introduced.

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14 Q. BY MR. IKEDA: Mr. Haaven, in front of you
15 is what's been marked as Exhibit 8.

16 Do you recognize that document?

17 A. Yes.

18 Q. What is it?

19 A. It's our site visit report for MSOP for
20 2012.

21 Q. And so that's the report that you and the
22 two others drafted; correct?

23 A. That's right.

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15 Q. BY MR. IKEDA: So, Mr. Haaven, are you
16 familiar -- I think in your December 2012 report, so
17 that's Exhibit 8 that you have in front of you, you
18 -- A couple of the things that you identified in the
19 "facility and treatment environment" section, so
20 we're looking on page 12 and 13 --

21 A. Yes.

22 Q. -- is you testified about how you and the
23 two other experts were skeptical about the AMS, how
24 useful the AMS would be, and it turned out to be
25 positive. Right?

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1 A. Yes.

2 Q. And then one of the other things you
3 identified was clients -- if you look at the last
4 sentence of the second paragraph: "Clients are also
5 being allowed to choose roommates with staff
6 approval, which the clients also see as positive."

7 Do you see that as a positive development
8 for MSOP?

9 A. Yes.

10 Q. And why is that?

11 A. Well, again, I think that who you live
12 with is a very significant decision that a person is
13 allowed to have.

14 Q. Does that go to sort of the theme that we
15 had talked about earlier regarding the softening of
16 MSOP?

17 A. Softening of the environment and the
18 empowering, clients feeling more empowered.

19 Q. Because, in fact, in January -- in your
20 January 2014 report, in that same section, you talk
21 about how the environment is less restrictive and
22 clients have more freedom of movement; right?

23 A. Yeah. You said 2014?

24 Q. January of -- So that would be --

25 A. Oh, yeah.

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1 Q. -- your 2013 report?

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2 Q. Do you see that at other programs?
3 Specifically when you were at Wisconsin, did they
4 use double bunking?

5 A. Boy, I can't remember now. All I know is
6 some -- most programs had multiple housing and
7 double bunking. Some do not, but my experience is
8 that the majority have that, but I'm trying think.

9 Let me think here. Wisconsin? It seemed
10 to me in Wisconsin most of the housing was single.

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familiar with any
17 person in the MSOP program, who has been discharged
18 from the program without participating in treatment?
19 A. No.

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21 Q. Okay. We can move on.

22 So, we were talking about phase 1 earlier,
23 and Mr. Ikeda, when he was questioning about you
24 that, he -- I believe your response was along the
25 lines of that phase 1 serves as a preparatory

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1 process before going to sex offender specific
2 treatment. Is that --

3 A. Yes.

4 Q. -- accurate?

5 So is sex offender specific treatment --
6 Outside of the benefits of the rule -- learning to
7 follow rules and the structure, is there a sex
8 offender specific treatment offered to a client in
9 phase 1 at MSOP?

10 A. Well, maybe I should -- Let me -- Let me
11 clarify.

12 When I say that it's more focused sex
13 offender specific, if we looked at "is it part of a
14 sex offender programming?" certainly the first stage
15 is, because the first stage is, again, motivation
16 and involvement and engagement of the individual in
17 the process. So, in a sense, that's the sex
18 offender specific focus. When you move to the next
19 phase, it's focusing more on the specific strategies
20 on how one manages their sexual offending pattern
21 itself. So that's sort of the distinction between
22 the two.

23 Q. But that sort of treatment regarding sex
24 offender specific patterns and offending, is that
25 offered in phase 1 at MSOP, as far as you know?

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¹ A. My understanding is that's not the intent.

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